STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

John M. Colmers
Chairman

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

George H. Bone, M.D.

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

Jack C. Keane

Bernadette C. Loftus, M.D.

Thomas R. Mullen

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

Patrick Redmon, Ph.D.
Executive Director

Stephen Ports
Principal Deputy Director
Policy and Operations

Gerard J. Schmith
Deputy Director
Hospital Rate Setting

Mary Beth Pohl
Deputy Director
Research and Methodology

491st MEETING OF THE HEALTH SERVICES COST REVIEW COMMISSION
September 5, 2012

EXECUTIVE SESSION
9:30 a.m.

1. **Provider-based MCO Alternative Rate Methodologies (ARMs)**

2. **Waiver Issues**

PUBLIC SESSION OF THE
HEALTH SERVICES COST REVIEW COMMISSION
10:15 a.m.

1. **Review of the Executive Session and Public Meeting Minutes of the July 11, 2012 Meeting**

2. **Comments from Secretary Joshua M. Sharfstein**

3. **Executive Director's Report**

4. **Docket Status – Cases Closed**

   2160N – Maryland General Hospital
   2163A – Johns Hopkins Health System
   2164N – Calvert Memorial Hospital
   2165A – University of Maryland Medical Center
   2166A – University of Maryland Medical Center
   2167A – Johns Hopkins Health System

5. **Docket Status – Cases Open**

   2168R – Garrett County Memorial Hospital
   2169A – University of Maryland Medical Center
   2170A – University of Maryland Medical Center
   2171A – University of Maryland Medical Center
   2172A – MedStar Health
   2173A – MedStar Health
   2174A – Johns Hopkins Health System

2175A – Johns Hopkins Health System
2176R – Good Samaritan Hospital
2177A – Maryland Physicians Care
2178A – Johns Hopkins Health System
2179A – MedStar Health

6. **Draft Recommendation on Outpatient Clinic Volume Adjustment**

7. **Report on Rate Year 2013 Maryland Hospital Acquired Conditions and Quality-based Reimbursement Results**

8. **Hearing and Meeting Schedule**

Executive Session Minutes
of the
Health Services Cost Review Commission

July 11, 2012

Upon motion made, Chairman Colmers called the meeting to order at 9:13 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 Antos, Bone, Keane, Loftus, and Mullen.

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

Also attending were Stan Lustman and Leslie Schulman Commission Counsel.

Item One

The Executive Director updated the Commissioners and the Commissioners discussed the progress of the waiver test modernization process and the current status of the waiver test.

The Executive Session was adjourned at 9:37 a.m.

MINUTES OF THE
490th MEETING OF THE
HEALTH SERVICES COST REVIEW COMMISSION

July 11, 2012

Chairman John Colmers called the meeting to order at 9:40 a.m. Commissioners Joseph R. Antos, Ph.D., George H. Bone, M.D., Jack C. Keane, Bernadette C. Loftus, M.D., and Thomas R. Mullen were also present.

END OF COMMISSIONER ANTOS' TERM

Chairman Colmers announced that today's meeting was likely the final meeting of Commissioner Antos' eight year term. The Chairman stated that Commissioner Antos served the citizens of Maryland with great commitment and distinction, and that he will be sorely missed.

REPORT OF THE EXECUTIVE SESSION OF JULY 11, 2012

Dennis N. Phelps, Associate Director-Audit & Compliance, summarized the minutes of the July 11, 2012 Executive Session.

ITEM I
EXECUTIVE AND PUBLIC SESSIONS OF JUNE 6, 2012

The Commission voted unanimously to approve the minutes of the June 6, 2012 Executive and Public Sessions.

ITEM II
EXECUTIVE DIRECTOR'S REPORT

Patrick Redmon, Ph.D., Executive Director, reported that Monitoring Maryland Performance (MMP) indicated that the rate of growth in charge per case increased by 6.65% for the year ended April 2012 compared to the year ended April 2011, which is substantially down from the 8.9% reported three months ago. Dr. Redmon noted that for that same period, the number of inpatient cases declined by 3.75%; inpatient revenue increased by 2.65%; outpatient revenue increased by 11.74%; and total revenue increased by 5.79%. According to Dr. Redmon, on a month-to-month basis, charge per case decreased 2.66% for April 2012 over April 2011with total revenue increasing 1.57%. For the first ten months of FY 2012 (July 2011 through April 2012), charge per case increased 6.12% as cases decreased by 3.42%, while inpatient and outpatient revenue increased by 2.49% and 11.57% respectively.

Dr. Redmon related that staff recently received a waiver test letter from the Centers for Medicare and Medicaid Services (CMS) with the results for the period from January 1, 1981 through March 31, 2011. The letter indicated that the relative waiver test cushion was 6.98%, i.e., if payments nationally were unchanged going forward, payments per discharge in Maryland could rise by 6.98% before failing the test. Dr. Redmon noted that the relative waiver test cushion was down from 9.13% in the last letter. However, based on trends, recent Commission actions, and current federal law, staff estimates that the waiver cushion at the end of FY 2013 will be 1.15%.

HONORING FORMER CHAIRMAN CHARLES O. FISHER, SR

Sadly, Chairman Colmers reflected on the passing last month of Charles O. Fisher, Sr. the Commission's longest serving Chairman. Mr. Colmers stated that he felt a particular honor in occupying the seat that Mr. Fisher once held, having served as Executive Director of the Commission when Mr. Fisher was Chairman. Mr. Colmers noted that Mr. Fisher was his boss, his mentor, and his friend for many years. Mr. Colmers stated that those who knew Mr. Fisher considered him a paragon of virtue and honor. He served his community in a remarkable fashion throughout his entire life. According to Mr. Colmers, Mr. Fisher steered the Commission through some difficult times in the late 1980s and 1990s. Chairman Colmers asked that a moment of silence be observed in memory of Charles O. Fisher, Sr.

ITEM III
DOCKET STATUS CASES CLOSED

2157N – Levindale Hospital
2158N - Civista Medical Center
2159N - Civista Medical Center
2161A - Johns Hopkins Health System
2162A - Johns Hopkins Health System

ITEM IV
DOCKET STATUS CASES OPEN

Maryland General Hospital – 2160N

On May 12, 2012, Maryland General Hospital ("MGH") filed a partial rate application with the HSCRC requesting the establishment of new rates for Chronic Care (CHR), Respiratory Dependent Care (RDS), and Recreational Therapy (REC) to be effective July 1, 2012. This application was necessary because of the relocation of 76 chronic care beds from University Specialty Hospital which is closing.

After review and analysis, staff recommended the following:

1) That a CHR rate of $478.10, per patient day, be approved effective July 11, 2012:
2) That a RDS rate of $1,002.23, per patient day, be approved effective July 11, 2012;

and
3) That a REC rate of $84.02, per RVU, be approved effective July 11, 2012.

The Commission voted unanimously to approve staff's recommendation.

Johns Hopkins Health System – 2163A

Johns Hopkins Health System ("System") filed an application with the HSCRC on May 30, 2012 on behalf of Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center (the Hospitals) for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System requests approval from the HSCRC to continue to participate in a global rate arrangement for solid organ and bone marrow transplant services with INTERLINK Health Services, Inc. for a period of one year beginning July 1, 2012.

The staff recommended 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 July 1, 2012; and that the approval be contingent upon the execution of the standard Memorandum of Understanding.

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

Calvert Memorial Hospital – 2164N

On June 12, 2012, Calvert Memorial Hospital ("Hospital") submitted a partial rate application to the Commission requesting a rate for Magnetic Resonance Imaging (MRI) services to be provided on-site to both inpatients and outpatients. This rate will replace the Hospital's currently approved rebundled MRI rate utilized to bill for off-site MRI services provided to inpatients of the Hospital. The Hospital requested the lower of a rate based on its costs and volumes, or the statewide median for MRI services. The effective date requested was July 1, 2012.

After reviewing the Hospital's application, the staff recommended:

1. That COMAR 10.37.10.07 requiring that rate applications be filed 60 days before the opening of a new service be waived;
2. That an MRI rate of $42.45 per RVU be approved effective July 1, 2012;
3. That no change be made to the Hospital's charge per case standard for MRI services; and;
4. That the MRI rate not be rate realigned until a full year's cost experience data have been reported to the Commission.

The Commission voted unanimously to approve staff's recommendation.

University of Maryland Medical Center – 2165A

University of Maryland Medical Center (the Hospital) filed an application with the HSCRC on June 12, 2012 for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The Hospital requests approval from the HSCRC to continue to participate in a global rate arrangement for liver and blood and bone marrow transplants for a period of one year with Cigna Health Corporation beginning July 1, 2012.

The staff recommended that the Commission: 1) waive the requirement that an application be filed 30 days prior to the effective date of an alternative rate determination arrangement; and 2) approve the Hospital's application for an alternative method of rate determination for liver and blood and bone marrow transplant services, for a one year period commencing July 1, 2012; and 3) that the approval be contingent upon the execution of the standard Memorandum of Understanding.

The Commission voted unanimously tom approve staff's recommendation.

University of Maryland Medical Center – 2166A

University of Maryland Medical Center (UMMC, or "the Hospital) filed a renewal application with the HSCRC on June 12, 2012 for an alternative method of rate determination pursuant to COMAR 10.37.10.06. The Hospital requests approval from the HSCRC to continue to participate in a global rate arrangement for the collection of peripheral blood stem cells from donors for a period of one year with the National Marrow Donor Program (NMDP) beginning July 1, 2012.

The staff recommended that the Commission: 1) waive the requirement that an application be filed 30 days prior to the effective date of an alternative method of rate determination arrangement; and 2) approve the Hospital's application for an alternative method of rate determination for the collection of peripheral stem cells for one year commencing July 1, 2012 that the approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU").

The Commission voted unanimously to approve staff's recommendation.

Johns Hopkins Health System – 2167A

Johns Hopkins Health System ("System") filed an application with the HSCRC on May 15,

2012 on behalf of Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center (the Hospitals) for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System requests approval from the HSCRC for participation in a global rate arrangement for solid organ and bone marrow transplant services with Blue Cross Blue Shield Blue Distinction Centers for Transplants for a period of one year beginning May 1, 2012.

The staff recommended 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 solid organ and bone marrow transplant services for a one year period commencing May 1, 2012; and 3) approve the application contingent upon the execution of the standard Memorandum of Understanding.

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

ITEM V
FINAL RECOMMENDATION REGARDING FY 2011AVERTED BAD DEBT RECONCILIATION, RECONCILIATION POLICY BEGINNING FY 2012, AND ADDRESSING NET COST CONTAINMENT AMOUNTS RELATED TO THE FY 2013 MEDICAID BUDGET

Jerry Schmith, Deputy Director-Hospital Rate Setting, summarized staff's recommendations for the reconciliation of the estimated FY 2011 Averted Bad Debts to actual and the proposed Averted Bad Debt Policy for FY 2012 and Beyond (see "Averted Bad Debt: Options for Reconciliation of FY 2011 Averted Bad Debt Estimates to Actual and Averted Bad Debt Policies for FY 2012 and Beyond" on the HSCRC's website).

Staff's recommendations for settling FY 2011 averted bad debt included: 1) projecting charges for June 2012 using claims from May 2012; 2) employing altered lower use and crowd out rates of 9% and 18.22% respectively in calculating averted bad debt for FY 2011; and 3) reducing hospitals' FY 2012 HealthCare Expansion assessment by the difference between actual averted bad debt and the assessment amount, $18.1 million.

Mr. Schmith noted that although there will be no reconciliation of expected to actual averted bad debt for FY 2012 (legislation mandates a uniform 1.25% of projected regulated net patient revenue for each hospital), the Maryland Hospital Association and hospital representatives have expressed interest in continuing the claim-specific reconciliation process at least in FY 2012 to equitably align the expected averted bad debt amount in each hospital's rates with the actual averted bad debts.

In order to perform the claim-specific reconciliation, staff recommended that for FY 2012: 1) the Commission facilitate the dissemination of Medicare expansion claims from the Department of Health and Mental Hygiene to hospitals; and 2) the Commission apply the crowd out and lower

use rates utilized in FY 2011to calculate actual averted bad debt.

Traci LaValle, Assistant Vice President-Financial Policy of the Maryland Hospital Association (MHA), noted that as in FY 2010 reconciliation, the key assumptions - - lower use rate and crowd out - - cannot be verified. If, for example, the lower use rate utilized in the original assumption was too high, according to Ms. LaValle, the assessment was set too high and the excess assessment funded the Medicaid budget short-fall. Ms. LaValle noted that there seems to be a trend - - i.e., the assessments in FY 2010 and 2011 were set too high, and the assessments for FY 2012 is probably set too high. Ms. LaValle observed that the line between whether the assessment are funding Medicaid expansion or are funding the overall Medicaid budget deficit has become blurry. However, in the spirit of cooperation and the need to focus on other priorities, MHA accepts staff's recommendations.

Commissioner Antos asked Ms. LaValle how do we know that hospitals overpaid if the assumptions cannot be calculated.

Ms. LaValle stated that according to the assumptions that we agree on, the assessment is still too high for FY 2011. If you look at how much the assessment has increased, how much the charges have increased, and the decline in the use rate, the trends just do not match up.

According to Mr. Schmith, both the hospitals and Medicaid made credible arguments; the problem then is deciding what number is reasonable. In the spirit of cooperation, staff, the hospitals, and Medicaid agreed to settle on these assumptions.

Commissioner Keane asked Mr. Schmith whether the change in the lower use rate is based on actual evidence.

Mr. Schmith stated that there was evidence that the use rate had declined. The problem that we had was we didn't know exactly what was causing the decline.

Commissioner Keane stated that what was concerning was that when we base a methodology prospectively on a set of assumptions and estimates, and then we retroactively change those estimates without very strong evidence that the original estimates or assumptions were wrong, two things happen: first, a lot of pressure is put on staff to acquiesce to a compromise, and secondly, the Commission undermines its own reputation as independent fact finders as opposed to Commissioners that compromise in situations where there are budgetary pressures, in this case, pressure from Medicaid. Mr. Keane stated that he strongly recommends that the Commission adopt a policy not to make such a change without strong evidence that the original estimates or assumptions were wrong. According to Commissioner Keane, it appears that there was no such strong evidence in this case.

The Commission voted unanimously to approve staff's recommendation.

ITEM VI
FINAL RECOMMENDATION ON THE CONTINUANCE OF, AND FUTURE MODIFICATIONS TO NSP I

Claudine Williams, Associate Director-Policy Analysis and Research, summarized staff's final Report on Nurse Support Activities for FY 2007 – FY 2012 and Recommendations for Refunding (see "Final Report on Nurse Support Activities for FY 2007 – FY 2012and Recommendations for Refunding" on the HSCRC's website).

The recommendations included: 1) work towards increasing the number of advanced degree nurses, demonstrate the link between improved nursing competency and patient outcomes; and support activities that advance the practice of nursing; 2) improve the application process; 3) revise the annual report to include 5-10 focused and well defined metrics; and 4) improve the oversight and monitoring of the NSP I program through routine site visits and budget audits.

Chairman Colmers asked what the timing was in letting hospitals know what the metrics are prior to their submission.

Ms. Williams stated that the metrics will be selected in the fall. In the winter, hospitals will submit commitment letters describing their programs and the metrics to be reported. The metrics then would be reported beginning FY 2014.

Commission voted unanimously to approve staff's recommendation.

ITEM VII
REPORT ON OUTPATIENT COST AND VOLUME TRENDS

In response to the Commission's charge to investigate, develop, and implement a new or modified outpatient revenue constraint system, Mary Beth Pohl, Deputy Director – Research and Methodology, stated that staff has begun investigating trends in the growth of outpatient services. Ms. Pohl provided several preliminary analyses indicating the overall growth of outpatient revenue versus inpatient revenue, growth in volume and revenue by rate center, and growth and volume grouped by ambulatory center (see "Outpatient Growth Analysis – July 11, 2012 – Final" on the HSCRC's website).

Chairman Colmers asked whether staff was able to determine increases in volumes associated with physician practices converting to hospital clinics.

Ms. Pohl noted that although staff believes that converting practices to clinics as well as bringing in more physicians to practice in regulated clinics are drivers of volume increases, their impact has not been determined.

Ms. Pohl also noted that TPR hospitals have the effect of dampening the volume increases in the

analyses because TPR hospitals have the incentive to reduce volumes. Consequently, staff will exclude TPR hospitals from future growth analyses.

Commissioner Keane asked how much of the increase in clinic visits is the result of recent substantial increases in the number of physicians employed by hospitals.

Ms. Pohl stated that she did not have that information; however, if hospital employed physicians were brought into practice in regulated hospital clinics, there would be volume growth.

Dennis Phelps, Associate Director-Audit & Compliance, stated that in the last five years, there had been a substantial number of hospital-owned physician practices converted to hospital clinics.

Commissioner Keane stated that it would be reasonable to assume that if a physician practice moved to a regulated clinic, the cost would increase. Commissioner Keane observed that if we move to a per capita waiver test, the Commission must provide hospitals with the incentive to control total costs, as in TPR hospitals, and not the incentive to increase revenue by moving outpatient services into hospitals as is now the case for non-TPR hospitals.

Commissioner Mullen pointed out that there is a decrease in physician reimbursement when physicians move from private practice to a clinic setting.

Commissioner Keane observed that providing outpatient services in the hospital is still, in most cases, the more costly option.

Chairman Colmers asked if staff were any closer to identifying what type of outpatient constraint system should be adopted.

Dr. Redmon stated that the purpose of this exercise is to determine what specific areas to focus on. Clinic was one of the areas. This is our first cut. We are not ready to provide the Commission with a process today. Our goal is to do more data analyses and to come back and discuss the findings.

ITEM VIII
LEGAL REPORT

Regulations

Proposed

Rate Application and Approval Procedures – COMAR 10.37.10.26

The purpose of this amendment is to permit patients of other means-tested social service programs to be deemed presumptively eligible for free care.

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

Final Adoption

Rate Application and Approval Procedures – COMAR 10.37.10.26

The purpose of this action is to notify hospital inpatients and outpatient of the potential for separate bills for hospital and physician services provided at the hospital.

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

ITEM XII
HEARING AND MEETING SCHEDULE

August 1, 2012	Meeting Cancelled
September 5, 2012	Time to be determined, 4160 Patterson Avenue, HSCRC Conference Room

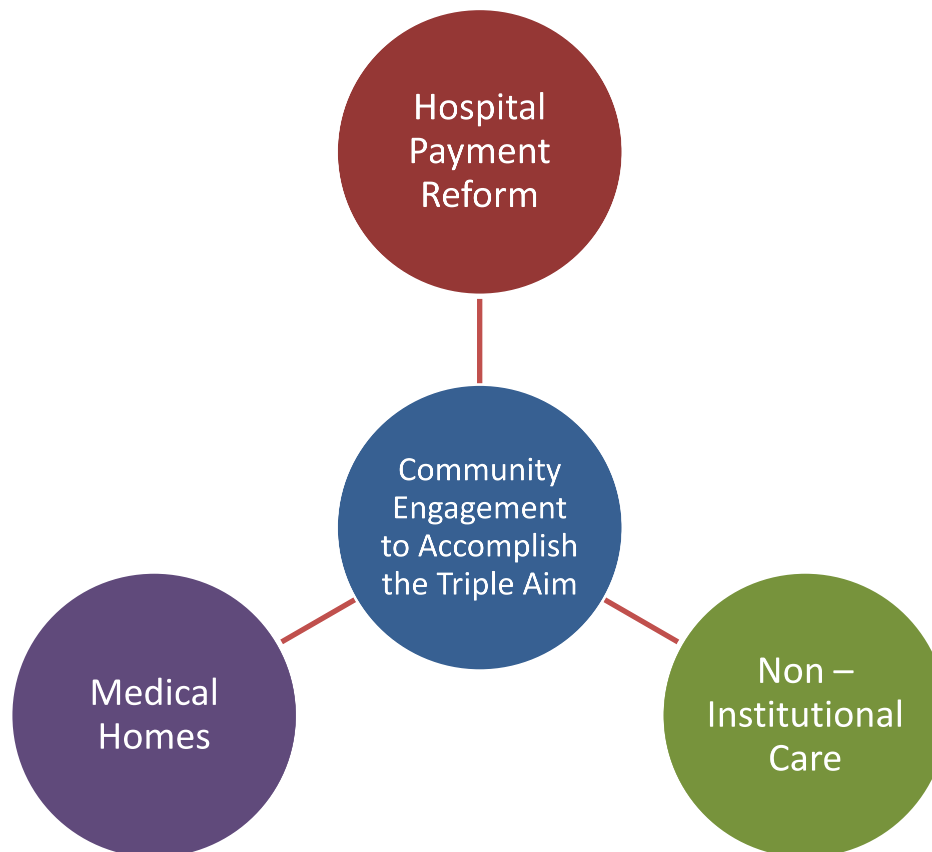
There being no further business, the meeting was adjourned at 10:42 a.m.

Health Care and Public Health in Maryland

Joshua M. Sharfstein, M.D.
Secretary
Department of Health and Mental Hygiene

September 2012

Maryland is seeking to accomplish the triple aim by aligning incentives to provide the right care at the right time to patients.



Community Engagement

MARYLAND

DEPARTMENT OF
HEALTH AND MENTAL HYGIENE

Search

Email Friend print page

HOME | EXECUTIVE SUMMARY | MEASURES | DISPARITIES | LOCAL ACTION | PUBLIC ENGAGEMENT

SHIP TOPIC OF THE MONTH
Health Literacy

HEALTH TIPS
What You Can Do To Improve Your Health

SHIP MEASURES
State Health Improvement Process Framework

TOOLBOX
Featured Tools
Other Tools

SHIP RESOURCES
Overarching References

State Health Improvement Process (SHIP)

Maryland State Health Improvement Process

Welcome Message from DHMH Secretary Dr. Sharfstein

Welcome to the website for Maryland's State Health Improvement Process. Our goal is to provide a framework for accountability, local action, and public engagement to advance the health of Marylanders.

Click here to see a set of 39 critical health measures. You can follow Maryland's progress as we seek to extend life expectancy, improve access to health care, reduce obesity, and move the needle on other critical health goals.

Click here to see what tools are available for your community to make progress on these and other key measures. Your community can learn who to talk to about traffic safety concerns, get free videos, and strategize with lawyers on innovative approaches to community health needs. I thank

Governor Martin O'Malley
Lt. Governor Anthony G. Brown

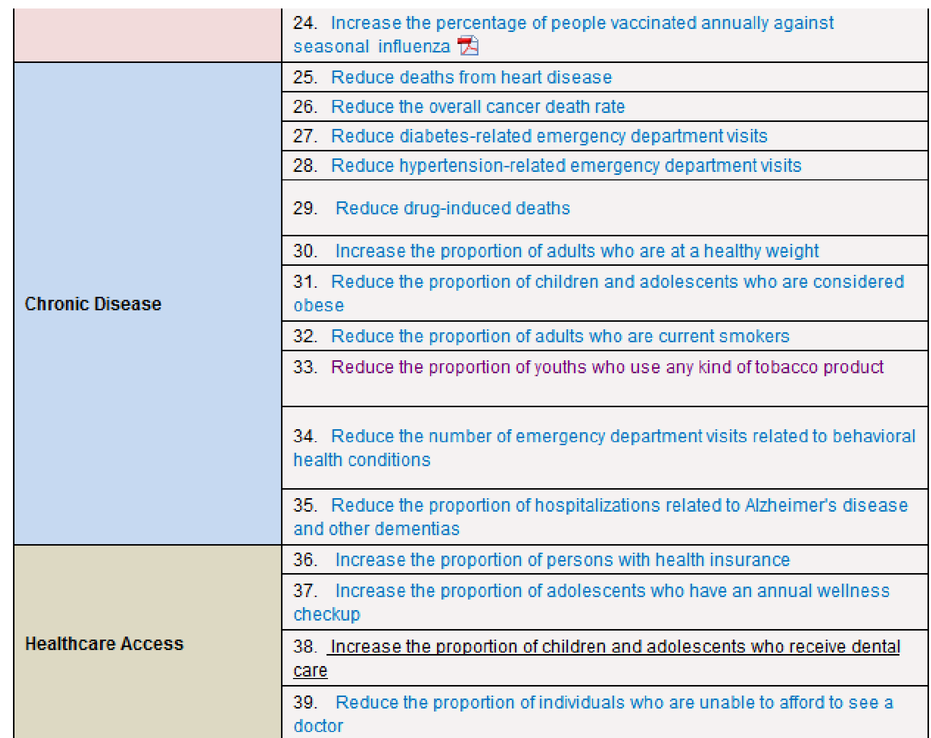
Contact Us
Share Your Questions & Comments

Latest News
Achieving Equity in Health (10-6-11)
Disparities Cloud Health Improvements Made In Past Decade, Report Finds (10-6-11)
Health Affairs - Agenda For Fighting Disparities (Oct.11)
Program Seeks to Break Isolation of Poor, Single Mothers, and Reduce Infant Deaths (9-26-11)
More News

Upcoming Events
American Public Health Association 139th Annual Meeting and Exposition (10-29,30,31,11-1&2-11)
SOPHE 62nd Annual Meeting - Leveraging the Power of

39 Key Measures

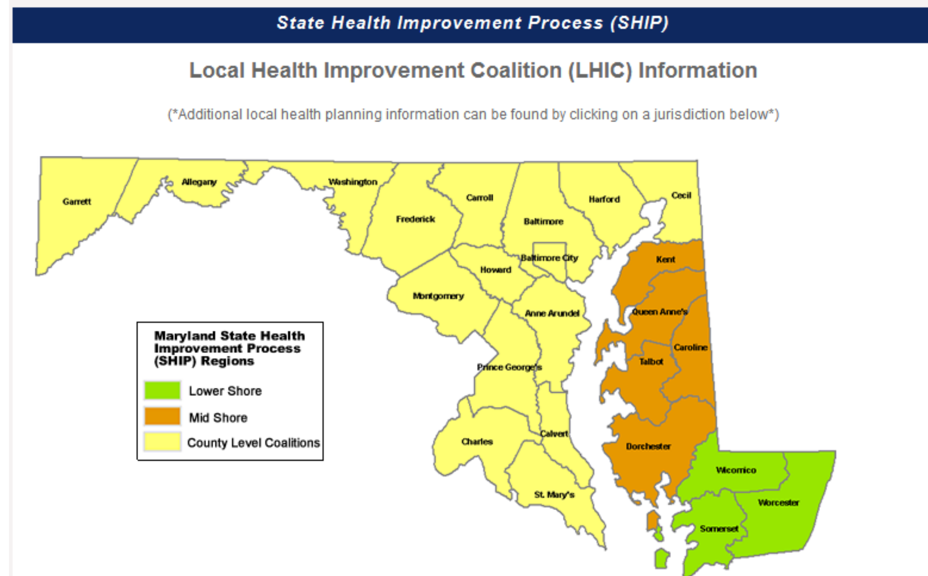
Vision Area	SHIP Objectives
	1. Increase life expectancy
Healthy Babies	2. Reduce infant deaths
	3. Reduce low birth weight (LBW) & very low birth weight (VLBW)
	4. Reduce sudden unexpected infant deaths (SUIDs)
	5. Increase the proportion of pregnancies that are intended
	6. Increase the proportion of pregnant women starting prenatal care in the first trimester
Healthy Social Environments	7. Reduce child maltreatment
	8. Reduce the suicide rate
	9. Decrease the rate of alcohol-impaired driving fatalities
	10. Increase the proportion of students who enter kindergarten ready to learn
	11. Increase the proportion of students who graduate high school
	12. Reduce domestic violence
Safe Physical Environments	13. Reduce blood lead levels in children
	14. Decrease fall-related deaths
	15. Reduce pedestrian injuries on public roads
	16. Reduce Salmonella infections transmitted through food
	17. Reduce hospital emergency department visits from asthma
	18. Increase access to healthy food
	19. Reduce the number of days the Air Quality Index (AQI) exceeds 100
Infectious Disease	20. Reduce new HIV infections among adults and adolescents
	21. Reduce Chlamydia trachomatis infections among young people
	22. Increase treatment completion rate among tuberculosis patients
	23. Increase vaccination coverage for recommended vaccines among young children



Vision Area	SHIP Objectives
	24. Increase the percentage of people vaccinated annually against seasonal influenza
Chronic Disease	25. Reduce deaths from heart disease
	26. Reduce the overall cancer death rate
	27. Reduce diabetes-related emergency department visits
	28. Reduce hypertension-related emergency department visits
	29. Reduce drug-induced deaths
	30. Increase the proportion of adults who are at a healthy weight
	31. Reduce the proportion of children and adolescents who are considered obese
	32. Reduce the proportion of adults who are current smokers
	33. Reduce the proportion of youths who use any kind of tobacco product
	34. Reduce the number of emergency department visits related to behavioral health conditions
	35. Reduce the proportion of hospitalizations related to Alzheimer's disease and other dementias
Healthcare Access	36. Increase the proportion of persons with health insurance
	37. Increase the proportion of adolescents who have an annual wellness checkup
	38. Increase the proportion of children and adolescents who receive dental care
	39. Reduce the proportion of individuals who are unable to afford to see a doctor

Key SHIP Elements

- Local community coalition
- Local health plans
- Coordinated action to address key health outcomes



Health Enterprise Zones

- **WHAT:**
  (1) Area that demonstrates measurable and documented health disparities & poor health outcomes,
  (2) Community-size (small), and
  (3) Designated by the State

- **WHY:**
  – Target State resources to reduce disparities, improve health outcomes and reduce costs, hospital admissions and readmissions

Health Enterprise Zones

- **HOW:**

  - Incentivize providers to increase service
  - Support innovative public health approaches
  - Address social determinants where possible
  - Attract diverse health providers
  - Effective & sustainable plan

- **WHO CAN APPLY:**
  - Non-profit community-based organization or local government agency

Next Steps

- Using data and maps to enhance outreach and spur additional collaboration

Medical Homes

- Critical support for primary care
- Two major programs working in the state
  - Maryland Health Care Commission
  - CareFirst
- Plan to develop a coordinated approach to medical homes and integrate with community health infrastructure

Non-Institutional Care

- Maryland Health Care Commission will evaluate options for transparency and quality reporting.
- Enhanced all-payer claims database will transition to public utility to allow better understanding of care in Maryland and to assist the development of appropriate bundles

Hospital Payment

- Maryland's rate system provides incredible opportunities to align incentives for the triple aim.
- The goal of a modernized waiver is to take advantage of these opportunities.

Health Delivery Reform Subcommittee

- Subcommittee of Health Reform Coordinating Council
- Co-Chairs:
  - John Colmers, Vice President of Health Care Transformation & Strategic Planning, Johns Hopkins Medicine
  - Laura Herrera, Chief Medical Officer, DHMH
- Charge: Track implementation of health care delivery reform efforts in MD and share best practices

http://dhmh.maryland.gov/innovations

MARYLAND

DEPARTMENT OF
HEALTH AND MENTAL HYGIENE

Problem Solver | Maryland.gov | Online Services | State Agencies | Phone Directory

Search this site...

Email Friend print page

INNOVATIONS | CLINICAL INNOVATIONS | FINANCING MECHANISMS | INTEGRATED PROGRAMS

A - Z Index A | B | C | D | E | F | G | H | I | J | K | L | M | N | O | P | Q | R | S | T | U | V | W | X | Y | Z

RECENTLY MODIFIED (5)

MARYLAND RESOURCES (2)

Maryland MAPS

MD iMap

HEALTHIEST MARYLAND

Innovations ▸ Home

Health Care Innovations in Maryland

Welcome

In this time of rising health care costs and tight budgets, Maryland's consumers, hospitals, clinicians, insurance plans and community groups are working together to develop creative programs that enhance patient care , improve population health and cut cost s .

About the Database

The health care projects featured in this database are already delivering care in the state of Maryland. Search below to learn more about the future of Maryland's health care, and some of the innovative tools that will get us there.

GO RAVENS

News Updates

DHMH News Updates

HDRS September Meeting: Reducing Readmissions

- White Paper on ARR
  - Compares interventions hospitals are using to evidence base
  - Identifies promising interventions that are not being implemented
- Presentations
  - ARR Plan at Lifebridge Health
    - RN home visits and case management
    - Care coordinators for patients transitioning from ED to nursing homes
    - Medication management post-discharge
  - Health Connect Program in Prince George's County
    - Based on Komen approach
    - Sends patients coming to ED directly to onsite primary care clinic
    - Root cause analysis to identify reasons for readmission
  - Delmarva Foundation

Potential Areas for HSCRC

- Share data to assist with public health efforts
- Review and support community collaboration
- Track community health outcomes
- Reward hospitals that make improvements in community health

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

AS OF AUGUST 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	10/10/2012	12/13/2012	FULL	GS	OPEN
2169A	University of Maryland Medical Center	7/3/2012	N/A	N/A	ARM	DNP	OPEN
2170A	University of Maryland Medical Center	7/3/2012	N/A	N/A	ARM	DNP	OPEN
2171A	University of Maryland Medical Center	7/3/2012	N/A	N/A	ARM	DNP	OPEN
2172A	MedStar Health	7/25/2012	N/A	N/A	ARM	DNP	OPEN
2173A	MedStar Health	7/25/2012	N/A	N/A	ARM	DNP	OPEN
2174A	Johns Hopkins Health System	5/30/2012	N/A	N/A	ARM	DNP	OPEN
2175A	Johns Hopkins Health System	5/30/2012	N/A	N/A	ARM	DNP	OPEN
2176R	Good Samaritan Hospital	8/8/2012	9/7/2012	1/7/2013	DEF/MSG	CK	OPEN
2177A	Maryland Physicians Care	8/14/2012	N/A	N/A	ARM	SP	OPEN
2178A	Johns Hopkins Health System	8/17/2012	N/A	N/A	ARM	SP	OPEN
2179A	MedStar Health	8/17/2012	N/A	N/A	ARM	SP	OPEN

PROCEEDINGS REQUIRING COMMISSION ACTION - NOT ON OPEN DOCKET

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION	*	**COMMISSION**	
UNIVERSITY OF MARYLAND	*	**DOCKET:**	**2012**
MEDICAL CENTER	*	**FOLIO:**	**1979**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2169A**

Staff Recommendation

September 5, 2012

I. INTRODUCTION

University of Maryland Medical Center ("Hospital") filed an application with the HSCRC on July 3, 2012 for an alternative method of rate determination pursuant to COMAR 10.37.10.06. The Hospital requests approval from the HSCRC for continued participation in global rates for solid organ transplant, gamma knife, and blood and bone marrow transplants for three years with Aetna Health, Inc. beginning August 1, 2012.

II. OVERVIEW OF THE APPLICATION

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

III. FEE DEVELOPMENT

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

IV. IDENTIFICATION AND ASSESSMENT OF RISK

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

V. STAFF EVALUATION

Staff reviewed the experience under this arrangement and found it to be favorable. Staff believes that the Hospital can continue to achieve favorable performance under this arrangement.

VI. STAFF RECOMMENDATION

Based on the Hospital's favorable performance, staff recommends that the Commission: 1) waive the requirement that an application be filed 30 days prior to the effective date of an alternative rate determination arrangement; and 2) approve the Hospital's application for an alternative method of rate determination for solid organ transplant, gamma knife, and blood and bone marrow transplant services, for a one year period beginning August 1, 2012. The Hospital will need to file a renewal application to be considered for continued participation.

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

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION	*	**COMMISSION**	
UNIVERSITY OF MARYLAND	*	**DOCKET:**	**2012**
MEDICAL CENTER	*	**FOLIO:**	**1980**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2170A**

Staff Recommendation

September 5, 2012

I. INTRODUCTION

The University of Maryland Medical Center ("Hospital") filed an application with the HSCRC on July 3, 2012 requesting approval to continue participation in a global rate arrangement with Maryland Physicians Care ("MPC") for solid organ and blood and bone marrow transplant services for a period of one year beginning August 23, 2012.

II. OVERVIEW OF APPLICATION

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

III. FEE DEVELOPMENT

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

IV. IDENTIFICATION AND ASSESSMENT OF RISK

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

V. STAFF EVALUATION

Staff found that the actual experience under the arrangement for the last year has been favorable.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospital's application for an alternative method of rate determination for solid organ and blood and bone marrow transplant services, for a one year period commencing August 23, 2012. The Hospital will need to file a renewal application for review to be considered for continued participation.

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

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION	*	**COMMISSION**	
UNIVERSITY OF MARYLAND	*	**DOCKET:**	**2012**
MEDICAL CENTER	*	**FOLIO:**	**1981**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2171A**

Staff Recommendation

September 5, 2012

INTRODUCTION

The University of Maryland Medical Center ("Hospital") filed a renewal application with the HSCRC on July 3, 2012 requesting approval to continue to participate in a global rate arrangement for blood and bone marrow transplants for three years with the BlueCross and BlueShield Association Quality Centers for Transplant (BQCT) beginning September 1, 2012.

II. OVERVIEW OF APPLICATION

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

III. FEE DEVELOPMENT

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

IV. IDENTIFICATION AND ASSESSMENT OF RISK

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

V. STAFF EVALUATION

The staff found that the actual experience under this arrangement for the prior year has been favorable.

STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospital's application for an alternative method of rate determination for solid organ and blood and bone marrow transplant services, for a one year period commencing September 1, 2012. The Hospital will need to file a renewal application for review to be considered for continued participation.

Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospital for the approved contract. This document will formalize the understanding between the Commission and the Hospital, and will include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cann-ot be used to justify future requests for rate increases.

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION	*	**COMMISSION**	
MEDSTAR HEALTH	*	**DOCKET:**	**2012**
	*	**FOLIO:**	**1982**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2172A**

Staff Recommendation

September 5, 2012

I. INTRODUCTION

MedStar Health filed an application with the HSCRC on July 25, 2012 on behalf of Union Memorial Hospital and Good Samaritan Hospital (the "Hospitals") for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. Medstar Health requests approval from the HSCRC for continued participation in a global rate arrangement for cardiovascular services with the Kaiser Foundation Health Plan of the Mid-Atlantic, Inc. for one year beginning October 1, 2012.

II. OVERVIEW OF APPLICATION

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

III. FEE DEVELOPMENT

The hospital portion of the global rates was renegotiated in 2007. The remainder of the global rate is comprised of physician service costs. Also in 2007, additional per diem payments were negotiated for cases that exceed the outlier threshold.

IV. IDENTIFICATION AND ASSESSMENT OF RISK

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

V. STAFF EVALUATION

The staff reviewed the results of last year's experience under this arrangement and found that they were favorable. 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' request for continued participation in the alternative method of rate determination for cardiovascular services for a one year period commencing October 1, 2012. The Hospitals will need to file a renewal application for review to be considered for continued participation.

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

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION	*	**COMMISSION**	
MEDSTAR HEALTH	*	**DOCKET:**	**2012**
	*	**FOLIO:**	**1983**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2173A**

Staff Recommendation

September 5, 2012

I. INTRODUCTION

MedStar Health filed an application with the HSCRC on July 25, 2012 on behalf of Union Memorial Hospital and Good Samaritan Hospital (the "Hospitals") to participate in an alternative method of rate determination, pursuant to COMAR 10.37.10.06. Medstar Health requests approval from the HSCRC for continued participation in a global rate arrangement for orthopedic services with MAMSI for a one year period beginning September 1, 2012.

II. OVERVIEW OF APPLICATION

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

III. FEE DEVELOPMENT

The hospital portion of the global rates was developed by calculating the mean historical charges for 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 HRMI for all contracted and covered services. HRMI is responsible for billing the payer, collecting payments, disbursing payments to the Hospitals at their full HSCRC approved rates, and reimbursing the physicians. The Hospitals contend that the arrangement between HRMI and the Hospitals holds the Hospitals harmless from any shortfalls in payment from the global price contract.

V. STAFF EVALUATION

The staff reviewed the experience under this arrangement for the last year and found that it was favorable. The 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' request for continued participation in the alternative method of rate determination for orthopedic services, for a one year period, commencing September 1, 2012. The Hospital will need to file a renewal application for review to be considered for continued participation.

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

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION	*	**COMMISSION**	
JOHNS HOPKINS HEALTH	*	**DOCKET:**	**2012**
SYSTEM	*	**FOLIO:**	**1984**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2174A**

Staff Recommendation

September 5, 2012

I. INTRODUCTION

On July 30, 2012, Johns Hopkins Health System ("System") filed an alternative rate application 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 to continue to participate in a global rate arrangement with the Canadian Medical Network which combines two previously approved arrangements. The combined 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 September 1, 2012.

II. OVERVIEW OF APPLICATION

The contract will continue to be held and administered by Johns Hopkins HealthCare, LLC ("JHHC"), which is a subsidiary of the System. JHHC will 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 approve the Hospitals' application for an alternative method of rate determination for cardiovascular procedures, kidney transplant services, and bone marrow transplant services for one year beginning September 1, 2012. 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	*	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION	*	**COMMISSION**	
JOHNS HOPKINS HEALTH	*	**DOCKET:**	**2012**
SYSTEM	*	**FOLIO:**	**1985**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2175A**

Staff Recommendation

September 5, 2012

I. INTRODUCTION

Johns Hopkins Health System ("System") filed a renewal application with the HSCRC on July 30, 2012 on behalf of the Johns Hopkins Bayview Medical Center (the "Hospital") requesting approval from the HSCRC for continued participation in a capitation arrangement among the System, the Maryland Department of Health and Mental Hygiene (DHMH), and the Centers for Medicare and Medicaid Services (CMS). The Hospital, doing business as Hopkins Elder Plus ("HEP"), serves as a provider in the federal "Program of All-inclusive Care for the Elderly" ("PACE"). Under this program, HEP provides services for a Medicare and Medicaid dually eligible population of frail elderly. The requested approval is for a period of one year effective September 1, 2012.

II. OVERVIEW OF APPLICATION

The parties to the contract include the System, DHMH, and CMS. The contract covers medical services provided to the PACE population. The assumptions for enrollment, utilization, and unit costs were developed on the basis of historical HEP experience for the PACE population as previously reviewed by an actuarial consultant. The System will assume the risks under the agreement, and all Maryland hospital services will be paid based on HSCRC rates.

III. STAFF EVALUATION

Staff found that the experience under this arrangement for FY 2012 was favorable.

III. STAFF RECOMMENDATION

Staff recommends that the Commission approve the Hospital's renewal application for an alternative method of rate determination for one year beginning September 1, 2012. The Hospital will need to file a renewal application for review to be considered for continued participation.

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

includes 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 also stipulates that operating losses under the contract cannot be used to justify future requests for rate increases.

IN RE: THE ALTERNATIVE	*	**BEFORE THE HEALTH**	
RATE APPLICATION OF	*	**SERVICES COST REVIEW**	
MARYLAND GENERAL HOSPITAL	*	**COMMISSION**	
SAINT AGNES HEALTH			
	*	**DOCKET:**	**2012**
WESTERN MARYLAND HEALTH SYSTEM	*	**FOLIO:**	**1987**
MERITUS HEALTH	*	**PROCEEDING:**	**2177A**

Draft Recommendation

August 29, 2012

I. Introduction

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

II. Background

Under the Medicaid Health Choice Program, MPC, a Managed Care Organization ("MCO") sponsored by the Hospitals, is responsible for providing a comprehensive range of health care benefits to Medical Assistance enrollees. The application requests approval for the Hospitals to provide inpatient and outpatient hospital services as well as certain non-hospital services, in return for a State-determined capitation payment. Maryland Physicians Care pays the Hospitals HSCRC-approved rates for hospital services used by its enrollees. Maryland Physicians Care is a major participant in the Medicaid Health Choice program, and provides services on a statewide basis to about 20.2% of the total number of MCO enrollees in Maryland.

The Hospitals supplied information on their most recent experience and their preliminary projected revenues and expenditures for the upcoming year based on the initial revised Medicaid capitation rates.

III. Staff Review

This contract has been operating under previous HSCRC approval (Proceeding 2131A). Staff reviewed the operating performance under the contract as well as the terms of the capitation pricing agreement. Staff reviewed financial information and projections for CYs 2011 and 2012, and preliminary projections for CY 2013. In recent years, the financial performance of MPC has been favorable. The actual financial experience reported to staff for CY2011 was positive, and is expected to remain positive in CY 2012. However, the MCO projects an unfavorable financial outcome for CY 2013. This is due to a proposed significant reduction in capitation payments for CY 13.

IV. Recommendation

MPC has continued to maintain consistent favorable performance in recent years. However, the MCO expects the CY 13 rate cut to present a financial challenge. Based on past and projected performance, staff believes that the proposed renewal arrangement for MPC is acceptable under Commission policy but the Commission should continue to watch the impact of the CY 13 capitation payment reductions on the MCO's future financial posture, and any related surplus.

Therefore:

1. **Staff recommends approval of this alternative rate application for a one-year period beginning January 1, 2013.**
2. **Since sustained losses over an extended period of time may be construed as a loss contract necessitating termination of this arrangement, staff will continue to**

monitor financial performance to determine the impact of the CY 2013 Health Choice Program capitation payment reductions, and the MCOs expected financial status into CY 2014. Staff recommends that Maryland Physicians Care report to Commission staff (on or before the August 2013 meeting of the Commission) on the actual CY 2012 experience, preliminary CY 2013 financial performance (adjusted for seasonality) of the MCO, as well as projections for CY 2014.

(3) Consistent with its policy paper outlining a structure for review and evaluation of applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the continued adherence to the standard Memorandum of Understanding with the Hospitals for the approved contract. This document formalizes the understanding between the Commission and the Hospitals, and includes provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the managed care contract, quarterly and annual reporting, the confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU also stipulates that operating losses under managed care contracts may not be used to justify future requests for rate increases.

IN RE: THE ALTERNATIVE	*	**BEFORE THE HEALTH**	
RATE APPLICATION OF	*	**SERVICES COST REVIEW**	
THE JOHNS HOPKINS HEALTH	*	**COMMISSION**	
SYSTEM	*	**DOCKET:**	**2012**
	*	**FOLIO:**	**1988**
BALTIMORE, MARYLAND	*	**PROCEEDING**	**2178A**

Draft Recommendation

August 29, 2012

I. Introduction

On August 21, 2012 Johns Hopkins Health System ("JHHS," or the "System") filed an application for an Alternative Method of Rate Determination pursuant to COMAR 10.37.10.06 on behalf of Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, and Howard County General Hospital (the "Hospitals"). The System seeks renewal for the continued participation of Priority Partners, Inc. in the Medicaid Health Choice Program. Priority Partners, Inc. is the entity that assumes the risk under the contract. The Commission most recently approved this contract under proceeding 2135A for the period from January 1, 2012 through December 31, 2012. The Hospitals are requesting to renew this contract for a one-year period beginning January 1, 2013.

II. Background

Under the Medicaid Health Choice Program, Priority Partners, a provider-sponsored Managed Care Organization ("MCO") sponsored by the Hospitals, is responsible for providing a comprehensive range of health care benefits to Medical Assistance enrollees. Priority Partners was created in 1996 as a joint venture between Johns Hopkins Health Care (JHHC) and the Maryland Community Health System (MCHS) to operate an MCO under the Health Choice Program. Johns Hopkins Health Care operates as the administrative arm of Priority Partners and receives a percentage of premiums to provide services such as claim adjudication and utilization management. MCHS oversees a network of Federally Qualified Health Clinics and provides member expertise in the provision of primary care services and assistance in the development of provider networks.

The application requests approval for the Hospitals to continue to provide inpatient and

outpatient hospital services, as well as certain non-hospital services, in return for a State-determined capitation payment. Priority Partners pays the Hospitals HSCRC-approved rates for hospital services used by its enrollees. The Hospitals supplied information on their most recent experience and their preliminary projected revenues and expenditures for the upcoming year based on the initial revised Medicaid capitation rates.

Priority Partners is a major participant in the Medicaid Health Choice program, providing managed care services on a statewide basis through CY 2011 and serving 27.5% of the State's MCO population.

III. Staff Review

This contract has been operating under the HSCRC's initial approval in proceeding 2081A. Staff reviewed the operating performance under the contract as well as the terms of the capitation pricing agreement. Staff has analyzed Priority Partner's financial history, net income projections for CY 2012, and projections for CY 2013. The statements provided by Priority Partners to staff represent both a "standalone" and "consolidated" view of Priority's operations. The consolidated picture reflects certain administrative revenues and expenses of Johns Hopkins Health Care. When other provider-based MCOs are evaluated for financial stability, their administrative costs relative to their MCO business are included as well; however, they are all included under one entity.

In recent years, the financial performance of Priority Partners has been favorable. The actual financial experience reported to staff for CY2011 was positive, and is expected to remain positive in CY 2012. However, the MCO projects an unfavorable financial outcome for CY 2013. This is due to a proposed significant reduction in capitation payments for CY 13.

IV. Recommendation

Priority Partners has continued to achieve favorable financial performance in recent years. However, the MCO expects the CY 13 rate cut to present a financial challenge. Based on past and projected performance, staff believes that the proposed renewal arrangement for Priority Partners is acceptable under Commission policy but the Commission should continue to watch the impact of the CY 13 capitation payment reductions on the MCO's current and future financial posture, and any related surplus.

Therefore:

1) **Staff recommends approval of this alternative rate application for a one-year period beginning January 1, 2013.**
2) **Since sustained losses over an extended period of time may be construed as a loss contract necessitating termination of this arrangement, staff will continue to monitor financial performance to determine the impact of the CY 2013 Health Choice Program capitation payment reductions, and the MCOs expected financial status into CY 2014. Therefore, staff recommends that Priority Partners report to Commission staff (on or before the August 2013 meeting of the Commission) on the actual CY 2012 experience, and p reliminary CY 2013 financial performance (adjusted for seasonality) of the MCO, as well as projections for CY 2014.**
3) **Consistent with its policy paper outlining a structure for review and evaluation of applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the continued adherence to the standard**

Memorandum of Understanding with the Hospitals for the approved contract. This document formalizes the understanding between the Commission and the Hospitals, and includes provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the managed care contract, quarterly and annual reporting, the confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. T he MOU also stipulates that operating losses under managed care contracts may not be used to justify future requests for rate increases.

IN RE: THE ALTERNATIVE	*	**BEFORE THE HEALTH**	
RATE APPLICATION OF	*	**SERVICES COST REVIEW**	
MEDSTAR HEALTH	*	**COMMISSION**	
SYSTEM	*	**DOCKET:**	**2012**
	*	**FOLIO:**	**1989**
COLUMBIA, MARYLAND	*	**PROCEEDING:**	**2179A**

Draft Recommendation

August 29, 2012

I. Introduction

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

II. Background

Under the Medicaid Health Choice Program, MedStar Family Choice, a Managed Care Organization ("MCO") sponsored by the Hospitals, is responsible for providing a comprehensive range of health care benefits to Medical Assistance enrollees. The application requests approval for the Hospitals to provide inpatient and outpatient hospital services, as well as certain non-hospital services, in return for a State-determined capitation payment. MedStar Family Choice pays the Hospitals HSCRC-approved rates for hospital services used by its enrollees. MedStar Family Choice provides services to about 3.7% of the total number of MCO enrollees in Maryland.

The Hospitals supplied information on their most recent experience and their preliminary projected revenues and expenditures for the upcoming year based on the Medicaid capitation rates.

III. Staff Review

This contract has been operating under previous HSCRC approval (proceeding 2128A). Staff reviewed the operating performance under the contract as well as the terms of the capitation pricing agreement. Staff reviewed financial information and projections for CYs 2011 and 2012, and projections for CY 2013. In recent years, the financial performance of MFC has been favorable. The actual financial experience reported to staff for CY2011 was positive, and is expected to remain positive in CY 2012. MFC is projecting continued favorable performance in CY 2013.

IV. Recommendation

MFC has continued to achieve favorable financial performance in recent years. Based on past performance, staff believes that the proposed renewal arrangement for MFC is acceptable under Commission policy.

Therefore:

(1) Staff recommends approval of this alternative rate application for a one-year period beginning January 1, 2013.

(2) Since sustained losses may be construed as a loss contract necessitating termination of this arrangement, staff will continue to monitor financial performance to determine whether favorable financial performance is achieved in CY 2013, and expected to be sustained into CY 2014. Staff recommends that MedStar Family Choice report to Commission staff (on or before the August 2013 meeting of the Commission) on the actual CY 2012 experience and preliminary CY 2013 financial performance (adjusted for seasonality) of the MCO, as well as projections for CY 2014.

(3) Consistent with its policy paper outlining a structure for review and evaluation of applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the continued adherence to the standard Memorandum of Understanding with the Hospitals for the approved contract. This document formalizes the understanding between the Commission and the Hospitals, and includes provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the managed care contract, quarterly and annual reporting, the confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. T he MOU also stipulates that operating losses under managed care contracts may not be used to justify future requests for rate increases.

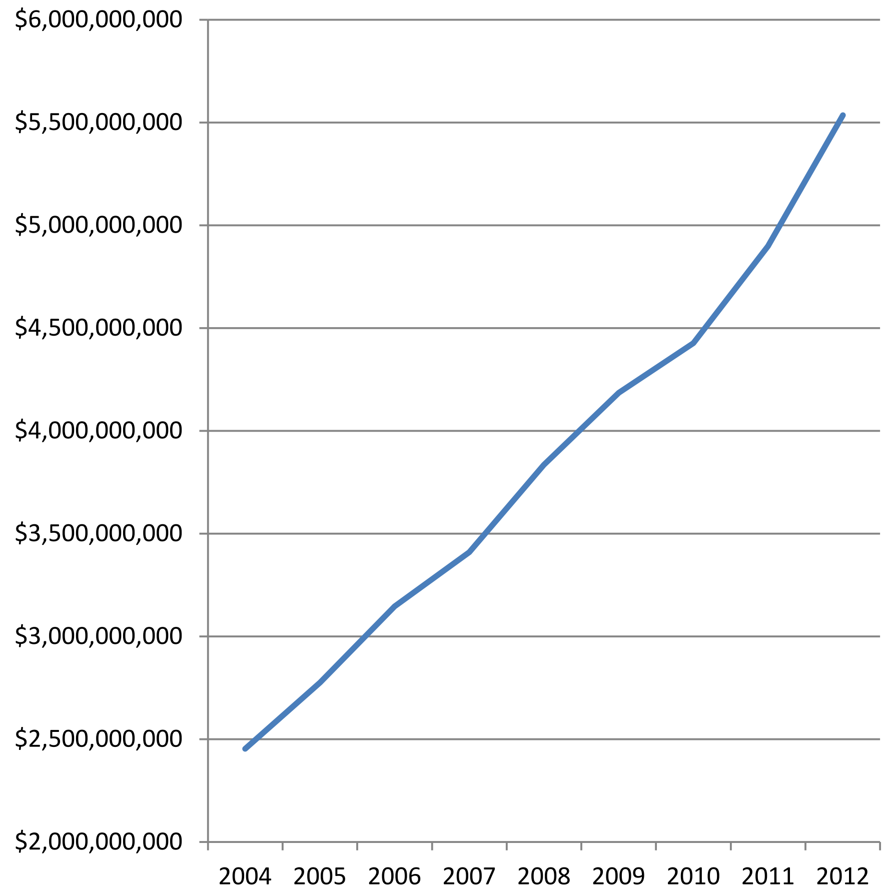
Outpatient Volume Adjustment: Clinic

Staff Report to the Commission

September 5, 2012

Outpatient Revenue is Growing

- As discussed at the July Commission meeting, outpatient revenue has grown significantly over the past ten years.
- As of June 2012, outpatient revenue grew $635,940,765 over the previous year.



Source: HSCRC, August 2012. Monitoring Maryland Performance Report.

The Commission Instructed Staff to Develop an Interim Outpatient Constraint Mechanism

- The Commission suspended the outpatient Charge Per Visit system at the March 7, 2012 Public Meeting.
- The Commission also instructed staff to develop a short-term outpatient constraint mechanism.
  - Methodologically straight-forward
  - Implement for fiscal year 2013

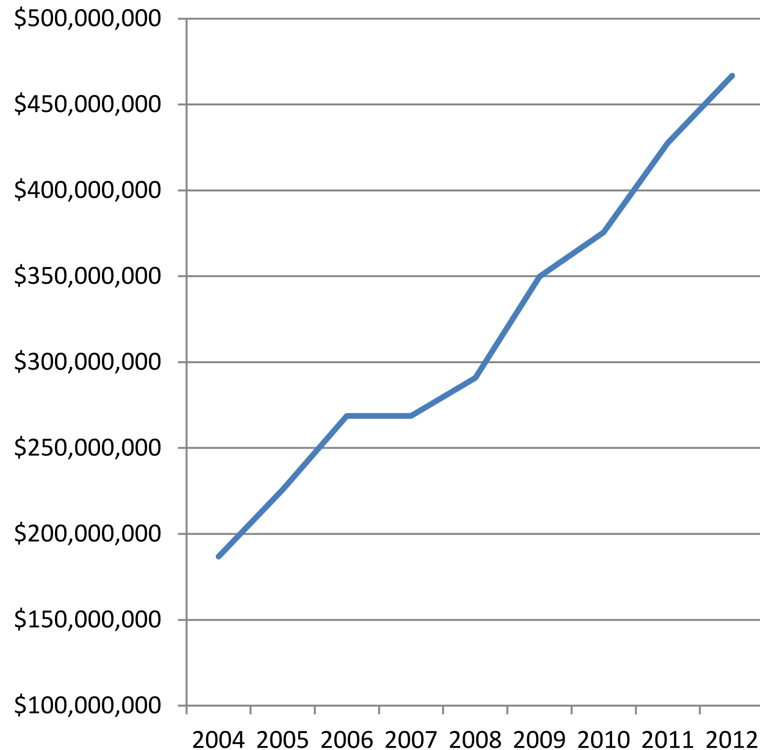
Staff Attribute Some Growth in Outpatient from Inpatient to Outpatient Shifts

- Federal policies, including RAC Audits, and Commission policy around one day stays have accelerated the movement of services from inpatient to outpatient.
  - HSCRC added an observation rate center in FY 2011
- Revenue increases expected in rate centers associated with inpatient to outpatient shift, such as same day surgeries and observation

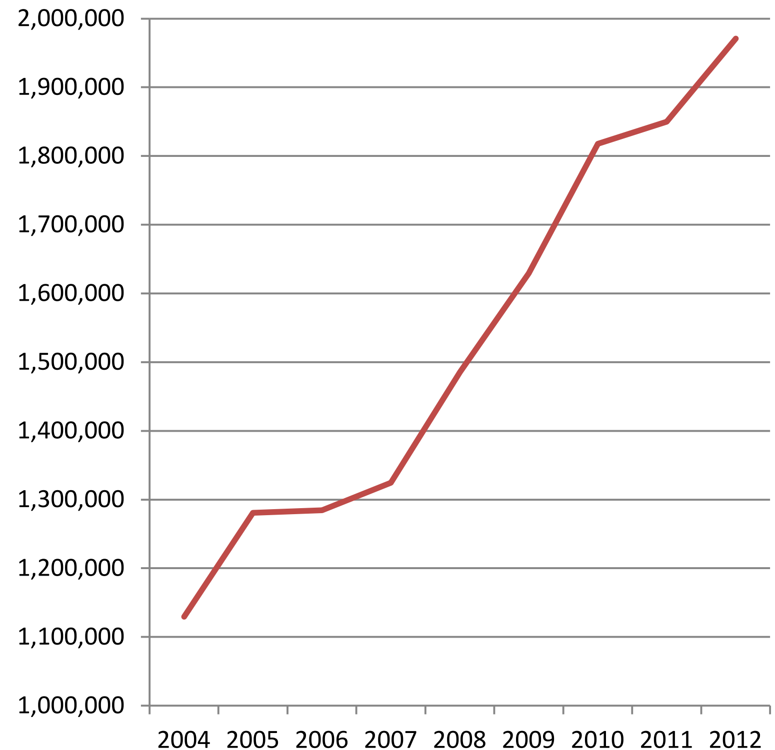
Bifurcated Annual Update Likely to Further Incentivize Outpatient Volume Growth

- Commission staff anticipate accelerated growth in outpatient revenue in fiscal year 2013 in part due to the Commission’s approval of an outpatient update larger than the inpatient update.

Similar to Overall Outpatient Revenue, Clinic Outpatient Revenue is Growing



Source: HSCRC, August 2012. Monthly Financial Data.
Notes: Maryland acute care hospitals, excludes TPR Hospitals



Source: HSCRC, August 2012. Monthly Financial Data.
Notes: Maryland acute care hospitals, excludes TPR Hospitals

Substantial Annual Growth in Outpatient Clinic Volume Adds Costs to the System

- HSCRC sets rates to cover fixed costs at the volume of services provided the previous year.
- Volume increases above the previous year generate 85 percent of approved rates under the current volume adjustment.
- To the degree that fixed costs are covered by the established rate, revenue from incremental volume increase falls to the hospital's bottom line.
- Staff is quantifying the excess system revenue from outpatient clinic growth.

HSCRC is Requesting Input from Payers to Understand Site of Service Differentials

- MedPac noted that under OPPS nationally, Medicare pays about 80 percent more for a 15-minute visit in an outpatient setting than in a freestanding physician office.
  - MedPac's March report recommended equalizing the payments.
- Maryland Medicaid reimburses equally for professional services in an outpatient setting and in a freestanding physician office. Therefore, all facility fees are fully additive to the cost to Medicaid.
- HSCRC staff is requesting data from other private payers and Medicaid.

Volume Increases in the Outpatient Clinic Setting have a Financial Impact on Payers

CareFirst Average Allowed Amount Comparisons for Select Evaluation and Management Procedure Codes Across Types of Care Settings, Maryland Providers Only

	Academic Medical Centers	**Urban/Suburban Community Hospital**	**Rural Community Hospital**
CPT Code and Description	**% of Office Allwd**	**% of Office Allwd**	**% of Office Allwd**
99203 Office outpatient new 30 minutes	233%	296%	275%
99213 Office outpatient visit 15 minutes	298%	308%	339%
99214 Office outpatient visit 25 minutes	247%	188%	257%
99215 Office outpatient visit 40 minutes	223%	166%	177%
99244 Office consultation new/estab patient 60 min	202%	226%	252%

Source: CareFirst, August 2012.
Notes: Professional Allowed is calculated at the Code level, associated Facility Allowed includes either all allowed at the case level. In Network Paid Claims between 07/01/2011 to 11/30/2011. Facility case selected with E&M CPT and without any accompanying ancillary procedures. Cases where the patient visited multiple providers were excluded from the data.

Volume Increases in the Outpatient Clinic Setting have a Financial Impact on Patients

- Recent national trends in purchased health plans show a shift to plans with high deductibles and increased co-insurance
- For a privately insured patient, an outpatient clinic visit has a higher out-of-pocket component than a comparable office visit.

Outpatient Clinic Volume Constraint is the First Step in Controlling Outpatient Volumes and Revenue

- HSCRC will recommend a 50 percent variable, 50 percent fixed volume adjustment.
- Volume adjustments aim to cover the variable cost of care and limit the amount of fixed costs covered through rates for incremental volume.

Outpatient Clinic Volume Constraint Has Limitations

- Only about 9 percent of outpatient revenue is in the clinic rate center.
- The constraint mechanism does not capture growth in ancillary services associated with greater use of clinic outpatient services.
- Depending on the base year, a volume constraint does not capture significant increases that occurred over the last five years.

HSCRC Staff is Holding a Workgroup

- The workgroup will address topics such as:
  - Discussion of data and trends
  - Adequacy of the 50/50 volume adjustment
  - Base year (with an understanding the Commission instructed this to be applied for rate year 2013)
  - Accounting for excess revenue from years of volume increases
  - Policy for future declines in volume
  - Other areas for targeted outpatient volume constraint
- Workgroup will meet next week

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

John M. Colmers
Chairman

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

George H. Bone, M.D.

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

Jack C. Keane

Bernadette C. Loftus, M.D.

Thomas R. Mullen

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

Patrick Redmon, Ph.D.
Executive Director

Stephen Ports
Principal Deputy Director
Policy and Operations

Gerard J. Schmith
Deputy Director
Hospital Rate Setting

Mary Beth Pohl
Deputy Director
Research and Methodology

To: HSCRC Commissioners

From: Dr. Sule Calikoglu, Associate Director of Performance Measurement

Date: August 29, 2012

Re: Rate Year (RY) 2013 Quality Based Reimbursement Initiative (QBR) and Maryland Hospital Acquired Conditions (MHAC) Results

---

This memorandum summarizes the results of the QBR and MHAC programs for RY 2013.

The QBR scores used for adjustments in RY2013 were based on hospital performance in clinical process of care measures and patient experience of care in calendar year 2011. The program redistributed a total of $7.9 million among 45 hospitals in a revenue neutral manner. The maximum penalty was set to 0.5 % of gross permanent inpatient revenue for RY2013. Exhibit 1 provides an analysis of average hospital rates in each measure included in the QBR program. The average rates continued to improve in 2011, with an average improvement of 2.4% for process of care measures, and of 3.1% in Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS).

As the MHAC program is transitioning from fiscal year to a calendar year based performance period, the performance period comprised of three quarters of data (Fiscal year (FY) 2012 quarters 1, 2 and 3) for RY2013. The maximum penalty was set to 2% of gross permanent inpatient revenue, which resulted in redistributing $16.7 million among 46 hospitals in a revenue neutral manner. Exhibit 2 provides changes in the first three quarters of FY2012 compared to FY2011. The rate of potentially preventable complications declined by 9.1% resulting in cost savings of $32 million.

Exhibit 1: Trends in Process of Care and Patient Experience Measures - 2008 to 2011

DOMAIN	Measure	State Hospital Average				Annual Change		
		2008	2009	2010	2011	2009	2010	2011
Average	Process of Care Measures	91.7%	93.2%	93.4%	95.8%	1.5%	1.7%	2.4%
	HCAHPS		65.3%	66.8%	69.8%		1.5%	3.1%
Heart Attack	AMI-1 Aspirin at Arrival	97.1%	97.4%	98.5%	98.5%	0.3%	1.1%	0.0%
	AMI-2 Aspirin prescribed at discharge	96.3%	96.4%	97.9%	98.6%	0.1%	1.6%	0.7%
	AMI-3 ACEI or ARB for LVSD	92.7%	93.2%	96.3%	97.5%	0.5%	3.1%	1.2%
	AMI-4 Adult smoking cessation advice/counseling	97.2%	98.4%	98.7%	99.5%	1.2%	0.3%	0.8%
	AMI-5 Beta blocker prescribed at discharge	95.7%	95.5%	96.9%	99.0%	-0.2%	1.4%	2.1%
	AMI-8a - Primary PCI Received Within 90 Minutes of Hospital Arrival	.	.	84.6%	90.3%			5.7%
Children Asthma Care	CAC-1a - Relievers for Inpatient Asthma (age 2 through 17 years) – Overall Rate	.	.	99.8%	100.0%			0.2%
	CAC-2a - Systemic Corticosteroids for Inpatient Asthma (age 2 through 17 years) – Overall Rate	.	.	99.5%	99.1%			-0.4%
	CAC-3-Home Management Plan of Care (HMPC) Document Given to Patient/Caregiver	.	.	62.9%	76.7%			13.7%
Heart Failure	HF-1 Discharge instructions	83.5%	86.7%	88.8%	91.7%	3.2%	2.1%	2.9%
	HF-2 Left ventricular systolic function (LVSF) assessment	95.0%	97.1%	97.6%	99.0%	2.1%	0.5%	1.4%
	HF-3 ACEI or ARB for LVSD	91.5%	93.1%	93.8%	96.1%	1.6%	0.6%	2.4%
	HF-4 Adult smoking cessation advice/counseling	96.4%	97.1%	98.9%	99.1%	0.7%	1.7%	0.2%
Pneumonia	PN-2 Pneumococcal vaccination	84.2%	88.9%	92.2%	95.0%	4.7%	3.4%	2.8%
	PN-3b Blood culture before first antibiotic – Pneumonia	89.9%	91.7%	93.7%	95.1%	1.8%	2.0%	1.4%
	PN-4 Adult smoking cessation advice/counseling	95.5%	95.9%	97.9%	98.5%	0.5%	1.9%	0.7%
	PN-6 Initial Antibiotic Selection for CAP in Immunocompetent Patient	90.8%	91.5%	91.8%	94.9%	0.7%	0.3%	3.1%
	PN-7 Influenza vaccination	78.6%	85.0%	90.0%	93.4%	6.4%	5.0%	3.4%
Surgical Care Improvement	SCIP CARD 2 Surgery Patients on Beta-Blocker Therapy Prior to Admission Who Received a Beta-Blocker During the Perioperative Period	91.1%	89.1%	92.9%	94.3%	-2.0%	3.8%	1.4%
	SCIP INF 1- Antibiotic given within 1 hour prior to surgical incision	92.4%	94.6%	96.1%	97.0%	2.3%	1.5%	0.9%
	SCIP INF 2- Antibiotic selection	96.0%	96.7%	96.9%	97.2%	0.8%	0.1%	0.3%

Exhibit 1: Trends in Process of Care and Patient Experience Measures - 2008 to 2011

DOMAIN	Measure	State Hospital Average				Annual Change		
	SCIP INF 3- Antibiotic discontinuance within appropriate time period postoperatively	88.4%	91.2%	93.9%	95.3%	2.8%	2.7%	1.3%
	SCIP INF 4- Cardiac Surgery Patients with Controlled 6 A.M. Postoperative Serum Glucose	.	.	87.8%	93.0%			5.2%
	SCIP INF 6- Surgery Patients with Appropriate Hair Removal	97.4%	99.5%	99.8%	99.8%	2.1%	0.3%	0.0%
	SCIP VTE 1- Surgery Patients with Recommended Venous Thromboembolism Prophylaxis Ordered	89.7%	90.0%	90.9%	96.5%	0.3%	0.9%	5.6%
	SCIP VTE 2 - Surgery Patients with Recommended Venous Thromboembolism Prophylaxis Given 24 hours prior and after surgery	87.2%	87.8%	89.3%	95.7%	0.6%	1.5%	6.4%
HCAHPS	Cleanliness of Hospital Environment	.	62.5%	64.2%	68.1%		1.7%	3.9%
	Communication About Medicines (Q16-Q17)	.	55.5%	57.5%	60.2%		2.0%	2.7%
	Communication With Doctors (Q5-Q7)	.	77.8%	78.1%	79.7%		0.3%	1.6%
	Communication With Nurses (Q1-Q3)	.	75.0%	76.3%	77.3%		1.3%	1.0%
	Discharge Information (Q19-Q20)	.	80.7%	81.4%	82.6%		0.7%	1.2%
	Overall Rating of this Hospital	.	60.7%	65.2%	69.4%		4.5%	4.2%
	Pain Management (Q13-Q14)	.	66.7%	67.4%	71.2%		0.6%	3.9%
	Quietness of Hospital Environment	.	52.0%	53.7%	58.5%		1.7%	4.8%
	Responsiveness of Hospital Staff (Q4,Q11)	.	57.3%	57.3%	60.6%		0.0%	3.3%
	Willingness to Recommend this Hospital	.	64.4%	66.5%	70.5%		2.1%	4.0%

Exhibit 2: State-Wide Changes in Potentially Preventable Complication Rates (PPC) and Costs in FY2012 Quarters 1, 2, and 3 Comprared to FY2011

PPC NUMBER/ PPC Name		OBSERVED NUMBER OF PPCs	PPC CHANGES COMPARED TO FY2011	TOTAL COST	COST CHANGES COMPARED TO FY2011	PERCENT CHANGE IN RATE	PERCENT CHANGE IN COST
Total		**28238**	**-2833**	**$349,439,424**	**-$32,000,399**	**-9.1%**	**-8.4%**
31	**Decubitus Ulcer**	117	-63	$3,914,131	-$2,413,196	-35.0%	-38.1%
10	**Congestive Heart Failure**	700	-265	$4,507,088	-$2,309,223	-27.5%	-33.9%
47	**Encephalopathy**	271	-97	$3,530,223	-$1,516,412	-26.3%	-30.1%
29	**Poisonings Except from Anesthesia**	78	-26	$166,608	-$47,808	-25.3%	-22.3%
51	**Gastrointestinal Ostomy Complications**	132	-30	$2,428,852	-$587,176	-18.3%	-19.5%
3	**Acute Pulmonary Edema and Respiratory Failure without Ventilation**	2221	-385	$20,335,850	-$4,747,970	-14.8%	-18.9%
35	**Septicemia & Severe Infections**	1036	-216	$22,654,590	-$4,998,124	-17.3%	-18.1%
48	**Other Complications of Medical Care**	387	-83	$6,886,733	-$1,451,175	-17.7%	-17.4%
45	**Post-procedure Foreign Bodies**	16	-4	$249,402	-$52,286	-21.1%	-17.3%
59	**Medical & Anesthesia Obstetric Complications**	536	-98	$387,360	-$67,115	-15.5%	-14.8%
11	**Acute Myocardial Infarction**	842	-119	$5,216,037	-$858,165	-12.4%	-14.1%
33	**Cellulitis**	324	-49	$1,967,660	-$323,436	-13.2%	-14.1%
49	**Iatrogenic Pneumothrax**	203	-25	$1,363,614	-$212,211	-10.9%	-13.5%
65	**Urinary Tract Infection without Catheter**	2142	-382	$24,493,727	-$3,217,202	-15.1%	-11.6%
26	**Diabetic Ketoacidosis & Coma**	30	-6	$142,210	-$17,649	-16.6%	-11.0%
5	**Pneumonia & Other Lung Infections**	1275	-141	$21,338,369	-$2,452,730	-9.9%	-10.3%
41	**Post-Operative Hemorrhage & Hematoma with Hemorrhage Control Procedure or I&D Proc**	136	-13	$1,864,072	-$213,544	-8.5%	-10.3%
17	**Major Gastrointestinal Complications without Transfusion or Significant Bleeding**	439	-47	$6,749,100	-$692,357	-9.6%	-9.3%
6	**Aspiration Pneumonia**	754	-76	$9,202,286	-$839,820	-9.2%	-8.4%
7	**Pulmonary Embolism**	382	-53	$5,278,682	-$477,336	-12.1%	-8.3%
42	**Accidental Puncture/Laceration During Invasive Procedure**	735	-109	$4,351,417	-$376,588	-12.9%	-8.0%
53	**Infection, Inflammation & Clotting Complications of Peripheral Vascular Catheters & Infusions**	154	-14	$1,026,825	-$86,458	-8.2%	-7.8%

Exhibit 2: State-Wide Changes in Potentially Preventable Complication Rates (PPC) and Costs in FY2012 Quarters 1, 2, and 3 Comprared to FY2011

PPC NUMBER/ PPC Name		OBSERVED NUMBER OF PPCs	PPC CHANGES COMPARED TO FY2011	TOTAL COST	COST CHANGES COMPARED TO FY2011	PERCENT CHANGE IN RATE	PERCENT CHANGE IN COST
24	Renal Failure without Dialysis	3507	-307	$26,652,756	-$2,196,189	-8.0%	-7.6%
16	Venous Thrombosis	706	-77	$13,615,093	-$917,238	-9.8%	-6.3%
27	Post-Hemorrhagic & Other Acute Anemia with Transfusion	640	-43	$4,506,386	-$300,683	-6.3%	-6.3%
19	Major Liver Complications	223	-9	$3,188,824	-$204,792	-4.0%	-6.0%
40	Post-Operative Hemorrhage & Hematoma without Hemorrhage Control Procedure or I&D Proc	1397	-103	$11,260,535	-$704,867	-6.9%	-5.9%
9	Shock	1072	-26	$17,821,859	-$1,084,544	-2.3%	-5.7%
1	Stroke & Intracranial Hemorrhage	586	-42	$9,559,881	-$569,460	-6.8%	-5.6%
44	Other Surgical Complication - Moderate	153	-2	$1,565,831	-$74,718	-1.6%	-4.6%
2	Extreme CNS Complications	198	-3	$2,667,910	-$118,521	-1.7%	-4.3%
23	GU Complications Except UTI	221	5	$1,698,000	-$49,924	2.2%	-2.9%
8	Other Pulmonary Complications	623	-33	$7,720,797	-$206,712	-5.1%	-2.6%
36	Acute Mental Health Changes	194	-1	$592,399	-$13,967	-0.5%	-2.3%
4	Acute Pulmonary Edema and Respiratory Failure with Ventilation	1037	-49	$31,500,405	-$565,530	-4.5%	-1.8%
54	Infections due to Central Venous Catheters	131	-16	$4,511,958	-$49,310	-10.7%	-1.1%
14	Ventricular Fibrillation/Cardiac Arrest	1179	-4	$21,713,844	-$160,811	-0.3%	-0.7%
20	Other Gastrointestinal Complications without Transfusion or Significant Bleeding	183	-2	$2,511,748	-$3,468	-1.3%	-0.1%
18	Major Gastrointestinal Complications with Transfusion or Significant Bleeding	183	-3	$3,212,577	$7,180	-1.8%	0.2%
52	Inflammation & Other Complications of Devices, Implants or Grafts Except Vascular Infection	607	7	$7,745,550	$62,384	1.2%	0.8%
34	Moderate Infectious	160	-16	$3,189,505	$82,195	-9.3%	2.7%
12	Cardiac Arrythmias & Conduction Disturbances	532	20	$2,060,940	$66,771	3.9%	3.4%
37	Post-Operative Infection & Deep Wound Disruption Without Procedure	351	-5	$5,674,988	$276,123	-1.4%	5.1%

Exhibit 2: State-Wide Changes in Potentially Preventable Complication Rates (PPC) and Costs in FY2012 Quarters 1, 2, and 3 Comprared to FY2011

PPC NUMBER/ PPC Name		OBSERVED NUMBER OF PPCs	PPC CHANGES COMPARED TO FY2011	TOTAL COST	COST CHANGES COMPARED TO FY2011	PERCENT CHANGE IN RATE	PERCENT CHANGE IN COST
50	**Mechanical Complication of Device, Implant & Graft**	308	32	$4,471,421	$396,451	11.6%	9.7%
39	**Reopening Surgical Site**	148	10	$3,606,126	$386,949	6.9%	12.0%
15	**Peripheral Vascular Complications Except Venous Thrombosis**	134	6	$2,611,304	$290,848	4.6%	12.5%
13	**Other Cardiac Complications**	157	25	$244,214	$33,425	18.7%	15.9%
28	**In-Hospital Trauma and Fractures**	102	19	$641,348	$89,303	23.5%	16.2%
25	**Renal Failure with Dialysis**	69	4	$3,304,446	$541,845	6.9%	19.6%
56	**Obstetrical Hemorrhage wtih Transfusion**	430	58	$1,156,364	$217,962	15.7%	23.2%
66	**Catheter-Related Urinary Tract Infection**	52	7	$1,030,059	$251,190	14.5%	32.3%
38	**Post-Operative Wound Infection & Deep Wound Disruption with Procedure**	45	17	$1,347,520	$475,694	59.8%	54.6%

Notes: Changes are adjusted for differences in patient mix. Cost estimates are based on FY2011 levels and adjusted for cost differences between hospitals. If the costs increase while the rates decline, this is a result of PPCs occuring in more costly hospitals.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

John M. Colmers
Chairman

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

George H. Bone, M.D.

Stephen F. Jencks

Jack C. Keane

Bernadette C. Loftus, M.D.

Thomas R. Mullen

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

Patrick Redmon, Ph.D.
Executive Director

Stephen Ports
Principal Deputy Director
Policy and Operations

Gerard J. Schmith
Deputy Director
Hospital Rate Setting

Mary Beth Pohl
Deputy Director
Research and Methodology

TO: Commissioners

FROM: Legal Department

DATE: August 29, 2012

RE: Hearing and Meeting Schedule

Public Session:

October 10, 2012	Time to be Determined, 4160 Patterson Avenue, HSCRC Conference Room
November 7, 2012	1:00 p.m., 4160 Patterson Avenue, HSCRC Conference Room

Please note, Commissioner packets will be available in the Commission's office at 9:00 a.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.
www.hscrc.state.md.us/commissionMeetingSchedule2012.cfm

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