Health Services Cost Review Commission
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512th MEETING OF THE HEALTH SERVICES COST REVIEW COMMISSION
October 15, 2014

EXECUTIVE SESSION
Noon

1. **Administrative Issues**

PUBLIC SESSION OF THE
HEALTH SERVICES COST REVIEW COMMISSION
1:00 p.m.

1. **Review of the Minutes from the Executive Session and Public Meeting on September 10, 2014**

2. **Executive Director's Report**

3. **New Model Monitoring**

4. **Docket Status – Cases Closed**
   2253N Fort Washington Medical Center
   2254A University of Maryland Medical Center
   2256A University of Maryland Medical Center
   2258A University of Maryland Medical Center
   2259A Johns Hopkins Health System
   2260R Holy Cross Germantown Hospital
   2261A Johns Hopkins Health System
   2262A Johns Hopkins Health System
   2263A Johns Hopkins Health System

5. **Docket Status – Cases Open**
   2257A MedStar Health
   2264N Bowie Emergency Facility
   2265A Holy Cross Hospital
   2266A Johns Hopkins Health System
   2267A University of Maryland Medical Center
   2268A University of Maryland Medical Center
   2269A Johns Hopkins Health System
   2270A St. Agnes Health, Maryland General Hospital, Meritus Health, Western Maryland Health System, and Holy Cross Health

2271A Johns Hopkins Health System
2272A Johns Hopkins Health System
2273A Johns Hopkins Health System

6. **Final Recommendation on CRISP Funding and Partnership**

7. **Final Recommendation for Updating the Quality Based Reimbursement Program for FY 2017**

8. **Global Budget Update**

9. **MHCC Presentation on the Medical Care Data Base**

10. **Hearing and Meeting Schedule**

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

AS OF OCTOBER 6, 2014

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
2257A	MedStar Health	7/17/2014	N/A	N/A	N/A	SP	OPEN
2264N	Bowie Emergency Facility	9/5/2014	11/4/2014	2//2/15	Rebundled CT	CK	OPEN
2265A	Holy Cross Hospital	9/5/2014	N/A	N/A	N/A	DNP	OPEN
2266A	Johns Hopkins Health System	9/5/2014	N/A	N/A	N/A	DNP	OPEN
2267A	University of Maryland Medical Center	9/18/2014	N/A	N/A	N/A	DNP	OPEN
2268A	University of Maryland Medical Center	9/18/2014	N/A	N/A	N/A	DNP	OPEN
2269A	Johns Hopkins Health System	9/25/2014	N/A	N/A	N/A	SP	OPEN
2270A	St. Agnes Health, Maryland General Hospital, Meritus Health, Western Maryland Health System, and Holy Cross Health	9/25/2014	N/A	N/A	N/A	SP	OPEN
2271A	Johns Hopkins Health System	9/25/2014	N/A	N/A	N/A	DNP	OPEN
2272A	Johns Hopkins Health System	9/30/2014	N/A	N/A	N/A	DNP	OPEN
2273A	Johns Hopkins Health System	10//1/14	N/A	N/A	N/A	DNP	OPEN

PROCEEDINGS REQUIRING COMMISSION ACTION - NOT ON OPEN DOCKET

IN RE: THE ALTERNATIVE	*	**BEFORE THE HEALTH**	
RATE APPLICATION OF	*	**SERVICES COST REVIEW**	
MEDSTAR HEALTH	*	**COMMISSION**	
SYSTEM	*	**DOCKET:**	**2014**
	*	**FOLIO:**	**2067**
COLUMBIA, MARYLAND	*	**PROCEEDING:**	**2257A**

Draft Recommendation

October 15, 2014

This is a draft recommendation and is intended from Commission action during the November 12, 2014 Commission Meeting. Any comments should be e-mailed to steve.ports@maryland.gov on or before October 31, 2014.

I. Introduction

On July 14, 2014, 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 2227A for the period from January 1, 2014 through December 31, 2014. The Hospitals are requesting to renew this contract for one year beginning January 1, 2015.

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 6.0% of the total number of MCO enrollees in Maryland, up from 4.1% in CY 2013.

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 2227A). 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 2013 and 2014, and projections for CY 2015. In recent years, the financial performance of MFC has been favorable. The actual financial experience reported to staff for CY 2013 was positive, and is expected to remain positive in CY 2014. MFC is projecting continued favorable performance in CY 2015.

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, 2015.

(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 2014, and expected to be sustained into CY 2015. Staff recommends that MedStar Family Choice report to Commission staff (on or before the September 2015 meeting of the Commission) on the actual CY 2014 experience and preliminary CY 2015 financial performance (adjusted for seasonality) of the MCO, as well as projections for CY

2015.

(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 PARTIAL RATE	*****	**BEFORE THE HEALTH SERVICES**
APPLICATION OF DIMENSIONS	*****	**COST REVIEW COMMISSION**
HEALTHCARE SYSTEM- BOWIE	*****	**DOCKET: 2014**
EMERGENCY CENTER	*****	**FOLIO: 2074**
BOWIE, MARYLAND	*****	**PROCEEDING: 2264N**

Staff Recommendation

October 15, 2014

Introduction

On September 5, 2014, Dimensions Healthcare System-Bowie Emergency Center (Bowie), a member of Dimensions Healthcare System, submitted an application to the Commission requesting a rebundled rate for CT Scanner (CAT) services; that its Global Revenue Budget (GBR) be increased for the new service; and that Bowie be included in the Uncompensated Care Policy (UCC). A rebundled rate is approved by the Commission when a hospital provides certain non-physician services through a third-party contractor off-site. By approving a rebundled rate, the Commission makes it possible for a hospital to bill for the services provided off-site, as required by Medicare. The Hospital requests that the rebundled CAT rate be set at the state-wide median and be effective October 13, 2014.

Background

It was brought to the attention of the Commission staff that because Bowie did not have a scanner, it was transporting registered patients to a non-hospital imaging center for CAT scans and the imaging center was billing patients and third-party payers for the scans. This is in violation of Medicare regulation (42 CFR §410.42) which requires that hospitals bill for all services provided to registered outpatients.

This application will provide Bowie with the ability to charge its patients for CAT services.

Staff Evaluation

As this service will be provided by a third-party contractor as a rebundled service, no cost finding is necessary. The state-wide median for CAT services is $6.99 per RVU.

Recommendation

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

1. That a CAT rate of $6.99 per RVU be approved October 13, 2014;
2. That, in order to ensure that there is no increase in cost to the public as a result of Bowie now appropriately billing for CAT services, the decision to adjust Bowie's GBR be deferred until FY 2015 CAT experience is available;
3. That the CAT rate not be rate realigned; and
4. That the issue of whether Free Standing Emergency Facilities should be included in the UCC Policy be considered for the FY 2016 UCC Policy.

IN RE: THE APPLICATION FOR	*****	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*****	**SERVICES COST REVIEW**	
DETERMINATION	*****	**COMMISSION**	
JOHNS HOPKINS HEALTH	*****	**DOCKET:**	**2014**
SYSTEM	*****	**FOLIO:**	**2076**
BALTIMORE, MARYLAND	*****	**PROCEEDING:**	**2266A**

Staff Recommendation

October 15, 2014

I. INTRODUCTION

Johns Hopkins Health System ("System") filed a renewal application with the HSCRC on September 5, 2014 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 December 1, 2014.

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 2014 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 Decmber 1, 2014. 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 APPLICATION FOR	*****	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*****	**SERVICES COST REVIEW**	
DETERMINATION	*****	**COMMISSION**	
UNIVERSITY OF MARYLAND	*****	**DOCKET:**	**2014**
MEDICAL CENTER	*****	**FOLIO:**	**2077**
BALTIMORE, MARYLAND	*****	**PROCEEDING:**	**2267A**

Staff Recommendation

October 15, 2014

I. INTRODUCTION

The University of Maryland Medical Center (the Hospital) filed a renewal application with the HSCRC on September 18, 2014 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 solid organ and blood and bone marrow transplant services with OptumHealth Care Solutions, Inc. for a one-year period, effective November 1, 2014.

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 regulated services associated with the contract.

III. FEE DEVELOPMENT

The hospital component 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 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. UPI maintains that it has been active in similar types of fixed fee contracts for several years, and that UPI is adequately capitalized to the bear risk of potential losses.

V. STAFF EVALUATION

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

been favorable.

VI. STAFF RECOMMENDATION

Staff recommends that the Commission approve the Hospital's application to continue to participate in an alternative method of rate determination for solid organ and blood and bone marrow transplant services for a one year period beginning November 1, 2014.

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:**	**2014**
MMEDICAL CENTER	*	**FOLIO:**	**2078**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2268A**

Staff Recommendation

October 15, 2014

I. INTRODUCTION

University of Maryland Medical Center (the Hospital) filed an application with the HSCRC on September 18, 2014 seeking approval 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 one year beginning November 1, 2014.

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 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 solid organ and blood and bone marrow transplant services at the Hospital. 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 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 among UPI, the Hospital, and the physicians holds the Hospital harmless from any shortfalls in payment from the global price contract. UPI maintains that it has been active in similar types of fixed fee contracts for several years, and that UPI is adequately capitalized to bear the risk of potential losses.

V. STAFF EVALUATION

Staff found that there was no experience under this contract for the previous year.

Although there was no experience last year, staff believes that the Hospital can achieve a favorable experience under this arrangement.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospital's application for an alternative method of rate determination for solid organ and blood and bone marrow transplant services for a one year period commencing November 1, 2014. 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 ALTERNATIVE	*	**BEFORE THE HEALTH**	
RATE APPLICATION OF	*	**SERVICES COST REVIEW**	
THE JOHNS HOPKINS HEALTH	*	**COMMISSION**	
SYSTEM	*	**DOCKET:**	**2014**
	*	**FOLIO:**	**2079**
BALTIMORE, MARYLAND	*	**PROCEEDING**	**2269A**

Draft Recommendation

October 15, 2014

This is a draft recommendation and is intended from Commission action during the November 12, 2014 Commission Meeting. Any comments should be e-mailed to steve.ports@maryland.gov on or before October 31, 2014.

I. Introduction

On September 24, 2014 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, Suburban Hospital, 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 2224A for the period from January 1, 2014 through December 31, 2014. The Hospitals are requesting to renew this contract for a one-year period beginning January 1, 2015.

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 to 22.8% of the State's MCO population, down from 26.4% in FY 2013.

III. Staff Review

This contract has been operating under the HSCRC's initial approval in proceeding 2224A. 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 2014, and projections for CY 2015. 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 consolidated financial performance of Priority Partners has been favorable. The actual financial experience reported to staff for CY2013 was positive, and is expected to remain favorable in CY 2014 and CY 2015.

IV. Recommendation

Priority Partners has continued to achieve favorable consolidated financial performance in recent years. Based on past and projected performance, staff believes that the proposed renewal arrangement for Priority Partners is acceptable under Commission.

Therefore:

1) **Staff recommends approval of this alternative rate application for a one-year period beginning January 1, 2015.**
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 in CY 2014, and the MCOs expected financial status into CY 2015. Therefore, staff recommends that Priority Partners report to Commission staff (on or before the September 2015 meeting of the Commission) on the actual CY 2014 experience, and preliminary CY 2015 financial performance (adjusted for seasonality) of the MCO, as well as projections for CY 2016.**
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**	
MARYLAND GENERAL HOSPITAL	*	**COMMISSION**	
SAINT AGNES HEALTH	*	**DOCKET:**	**2014**
WESTERN MARYLAND HEALTH SYSTEM	*	**FOLIO:**	**2080**
MERITUS HEALTH	*	**PROCEEDING:**	**2270A**
HOLY CROSS HEALTH			

Draft Recommendation

October 15, 2014

This is a draft recommendation and is intended from Commission action during the November 12, 2014 Commission Meeting. Any comments should be e-mailed to steve.ports@maryland.gov on or before October 31, 2014.

I. Introduction

On August 22, 2014, Maryland General Hospital, Saint Agnes Health System, Western Maryland Health System, Holy Cross Health, 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 2225A for the period January 1, 2014 through December 31, 2014. The Hospitals are requesting to renew this contract for one year beginning January 1, 2015.

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 to 18.4% of the total number of MCO enrollees in Maryland, down from 20% in CY 2013.

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

III. Staff Review

This contract has been operating under previous HSCRC approval (Proceeding 2225A). 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 2013 and 2014, and preliminary projections for CY 2015. In recent years, the financial performance of MPC has been favorable. The actual financial experience reported to staff for CY2013 was negative. However, financial performance is expected to be positive in CYs 2014 and 2015.

IV. Recommendation

With the exception of CY 2013, MPC has generally maintained favorable performance in recent years. Based on past and projected performance, staff believes that the proposed renewal arrangement for MPC is acceptable under Commission.

Therefore:

(1) Staff recommends approval of this alternative rate application for a one-year period beginning January 1, 2015.

(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 for CY 2014 and the MCOs expected financial status into CY 2015. Staff recommends that Maryland Physicians Care report to Commission staff (on or before the September 2015 meeting of the Commission) on the actual CY 2014 experience, preliminary CY 2015 financial performance (adjusted for seasonality) of the MCO, as well as projections for CY 2016.

(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 APPLICATION FOR	*****	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*****	**SERVICES COST REVIEW**	
DETERMINATION	*****	**COMMISSION**	
JOHNS HOPKINS HEALTH	*****	**DOCKET:**	**2014**
SYSTEM	*****	**FOLIO:**	**2081**
BALTIMORE, MARYLAND	*****	**PROCEEDING:**	**2271A**

Staff Recommendation

October 15, 2014

I. INTRODUCTION

Johns Hopkins Health System (the "System") filed an application with the HSCRC on September 25, 2014 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 MultiPlan, Inc. for a period of one year beginning November 1, 2014.

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 solid organ and bone marrow transplant services at the Hospitals. 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 will continue to be 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

Although there has been no activity under this arrangement, staff believes that the

Hospitals can 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 November 1, 2014. 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**	*	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION	*	**COMMISSION**	
JOHNS HOPKINS HEALTH	*	**DOCKET:**	**2014**
SYSTEM	*	**FOLIO:**	**2082**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2272A**

Staff Recommendation

October 15, 2014

I. INTRODUCTION

Johns Hopkins Health System (“System”) filed an application with the HSCRC on September 30, 2014 on behalf of Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center (the Hospitals) for renewal of a renegotiated 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 revised 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 November 1, 2014

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II. OVERVIEW OF APPLICATION

The contract will be 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 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 utilizing historical charges for patients receiving solid organ and bone marrow transplants at the Hospitals. 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 experience under this arrangement was unfavorable for the last year. However, the Hospitals have renegotiated the global prices and terms of the arrangement. After review, staff believes that the Hospitals can achieve favorable performance under this revised 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 November 1, 2014. 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	*****	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*****	**SERVICES COST REVIEW**	
DETERMINATION	*****	**COMMISSION**	
JOHNS HOPKINS HEALTH	*****	**DOCKET:**	**2014**
SYSTEM	*****	**FOLIO:**	**2083**
BALTIMORE, MARYLAND	*****	**PROCEEDING:**	**2273A**

Staff Recommendation

October 15, 2014

INTRODUCTION

Johns Hopkins Health System (System) filed a renewal application with the HSCRC on October 1, 2014 on behalf of the Johns Hopkins Bayview Medical Center (the "Hospital") for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System requests approval from the HSCRC for continued participation in a capitation arrangement serving persons with mental health needs under the program title, Creative Alternatives. The arrangement is between the Johns Hopkins Health System and the Baltimore Mental Health Systems, Inc., with the services coordinated through the Hospital. The requested approval is for a period of one year beginning November 1, 2014.

II. OVERVIEW OF APPLICATION

The parties to the contract include the System and the Baltimore Mental Health Systems, Inc. Creative Alternatives provides a range of support services for persons diagnosed with mental illness and covers medical services delivered through the Hospital. The System will assume the risks under the agreement, and all Maryland hospital services will be paid based on HSCRC rates.

III. STAFF FINDINGS

Staff found that the experience under this arrangement for FY 2014 was favorable.

IV. STAFF RECOMMENDATION

Staff recommends that the Commission approve the Hospital's renewal application for an alternative method of rate determination for a one year period commencing November 1, 2014.

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.

Final Recommendation:

Maryland's Statewide Health Information Exchange, the Chesapeake Regional Information System for our Patients: Additional FY 15 HSCRC Funding

October 15, 2014

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

This is a final recommendation to be presented at the October 15, 2014 HSCRC public meeting for Commission action.

Maryland's Statewide Health Information Exchange, the Chesapeake Regional Information System for our Patients:

Additional HSCRC Funding

Overview

In accordance with its statutory authority to approve alternative methods of rate determination consistent with the All-payer Model and the public interest (Health-General Article, Section 19-219(c)), this recommendation is to provide an additional $2 million of funding through hospital rates, above the existing $2.5 million limit approved by the Commission, for Chesapeake Regional Information System for our Patients (CRISP) for FY 2015, with the purpose of:

- Expanding staffing and operational capacity to support ad hoc analysis, monitoring and reporting services;
- Providing funds for engagement of resources to assist in evaluation and planning of possible statewide infrastructure and approaches for care coordination and physician alignment.

Background

In December 2013, the Commission adopted a recommendation to permit continued funding support for CRISP during FYs 2015 through FY 2019 not to exceed $2.5 million in any year.

During the May 2014 public meeting of the Commission, staff reported on funding support of CRISP's core operations in FY 2015 in the amount of $1.65 million. In June of 2014, the Commission approved additional funding of $850,000 for specific CRISP reporting services important to HSCRC's inter-hospital reporting capabilities. CRISP collects admission (or encounter), discharge, and transfer information from hospitals in a nearly real time basis. In the fall of 2013, HSCRC expanded the required collection of data by CRISP to include all hospital outpatient encounters. CRISP creates a master patient index using this and other data. The master patient index (a unique identifier number assigned to each person in the data base) can be attached to HSCRC abstract data, allowing the HSCRC to track readmissions across hospitals, transfers among hospitals, movement of patients across local, regional and statewide areas, and focusing on the care and health improvement needs of the population, including the nature and extent of use by high needs patients. This is a complex task that requires constant reconciliation between individual hospital transactional data and the HSCRC abstract data, which is now submitted on a monthly basis. This approach to linking information using the master patient index enhances the security and confidentiality of patient

information, such as name and address, because HSCRC does not collect this information in any data it receives. Through this process, the HSCRC is able to obtain the information it needs to expand its regulatory approaches to focus on population based measures while eliminating the need for HSCRC to collect or store highly identifiable data such as name and address.

When HSCRC staff considered the additional $850,000, it considered the potential for CRISP to provide various levels of reporting services to both hospitals and the HSCRC.

Unique ID Creation and Assignment

- CRISP links the unique master patient index ID to the HSCRC abstract data and provides the unique ID linkage to HSCRC staff for inter-hospital and other analysis. HSCRC staff has asked CRISP to accelerate production of this data and to do this on a monthly basis, in light of the need to track inter-hospital readmissions for the new All-Payer waiver, to track transfers among hospitals on a monthly basis, and to support the analysis of use of hospital services aggregated around populations, episodes, and patients.

Basic Cross-Entity Report Production for HSCRC

- CRISP obtains HSCRC abstract data in order to generate reports requested by HSCRC, such as inter-hospital readmission rates.

Standard Report Creation for Hospitals

- CRISP will provide hospitals with a core set of standard reports that require use of the unique patient identifier index on a monthly basis, such as inter-hospital readmissions, potentially avoidable utilization, and high needs patients.

New Funding Request

Additional Resources for Ad Hoc Analysis, Monitoring, and Reporting

The June 2014 staff report indicated that it would consider expanding the role of CRISP as the State's designated Health Information Exchange. Staff has been working with the Commission to evaluate approaches to meeting the expanded needs under the new All-Payer model as well as facilitating transparent availability of population based reports such as inter-hospital readmissions reports. By sharing the detailed analyses, the HSCRC expects to enhance information available to hospitals for care improvement and monitoring.

Maryland's Statewide Health Information Exchange, the Chesapeake Regional Information System for our Patients:

Additional HSCRC Funding

CRISP has been supporting ad hoc analysis for HSCRC staff focused on uncompensated care and Medicaid savings, among others. These analyses require the linking of Medicaid enrollment files with HSCRC abstract data. CRISP is able to support this analysis by linking the enrollment data with the master patient index database, which can then be linked to the HSCRC abstract. This has allowed analysis that could not previously be done in an accurate manner. Unless these activities are funded, they compete with other functions provided by CRISP.

With the expanding use of population based and patient centered measures, along with the requirements placed on CRISP by HSCRC staff for ad hoc analyses needed to assess Medicaid savings and uncompensated care trends, HSCRC staff is recommending an expanded level of funding to support additional resources for CRISP. Out of the $2 million recommendation for additional funding, approximately $1 million might be used to expand resources. The expanded services include:

- Ad hoc analyses of cost and utilization for Medicaid needed to measure savings under State statute;
- Further uncompensated care analytics related to the ACA expansion including the Primary Adult Care Program (PAC) expansion, other Medicaid enrollment expansions, and other analyses as needed;
- Reporting on Potential Avoidable Utilization (PAU) at the case level including regular detail and summary reports;
- Other population based reports;
- More detailed reporting on high utilizers of hospital care for the purpose of planning care management approaches; and
- Tableau programming to support report production.

The Maryland Hospital Association has provided a letter of support regarding this funding.

Evaluation and Planning Resources

The Physician Engagement and Alignment Workgroup and the Data and Infrastructure Workgroup made recommendations to the Commission that will require further evaluation. The recommendations from both of these Workgroups may require substantial investments in development and maintenance of statewide infrastructure. These recommendations, if implemented, would likely be organized outside of the HSCRC. These activities involve multiple State agencies as well as cooperation and

coordination among hospitals, physicians, long-term and post acute care resources, payers, and others.

The HSCRC staff and the Commission have been planning further implementation activities. The HSCRC staff presented an update on these planning activities along with proposed Workgroups to ensure stakeholder input into the process.

The HSCRC staff and the Commission have been discussing approaches to funding consulting and expert resource needs to support more detailed planning, evaluation, and stakeholder input relative to provider alignment and care coordination initiatives and infrastructure needs. These activities are outside of the ongoing recurring work of the HSCRC staff and require flexible agile approaches to convening stakeholders and planning resource requirements. Timing of this work is important for several reasons. First, hospitals are in the process of applying for and expanding accountable care and care coordination activities. These resource-intensive activities may be conducted more cost effectively with use of some statewide resources. Secondly, under the Budget Reconciliation and Financing Act of 2014 (BRFA), the State legislature approved possible funding of up to $15 million through hospital rates to support partnership and infrastructure activities for implementation of the new All-Payer model. Given the need for significant infrastructure relative to provider alignment and care coordination, areas that were recommended as priorities for consideration by the Advisory Council, HSCRC staff wants to complete more detailed planning for statewide resource needs that might be considered for funding prior to June 30, 2015.

HSCRC staff is recommending that CRISP in its role as the State's Health Information Exchange obtain the needed planning resources for these and similar activities. This approach is recommended because the activities represent the reasonable progression of work already delegated to CRISP. In addition, this approach shines a public light on the activities, while providing agility in meeting the demands of the All Payer Model through the Commission's alternative method rate setting authority. It also recognizes the progression of planning needed to implement the BRFA funding contemplated in the balanced update previously approved by the HSCRC. The HSCRC will use a Memorandum of Understanding (MOU) to ensure that the plans are laid out and executed as expected. HSCRC staff is proposing to earmark $1 million of the requested funding for these purposes. HSCRC staff recommends, therefore, that the planning and implementation funding included in this recommendation reduce the amount of BRFA funding available for implementation of the All-Payer Model from $15 million to

Maryland's Statewide Health Information Exchange, the Chesapeake Regional Information System for our Patients:

Additional HSCRC Funding

$14 million since the HSCRC will have allocated revenue capacity to implement a planning and implementation process that is needed to ensure stakeholder and public input into the approach that will be recommended to the Commission.

The Maryland Hospital Association supports this funding approach but has advocated for caution to ensure that funded activities benefit hospitals in the implementation of the new All-Payer Model. HSCRC staff agrees with this cautious approach, and we have focused our recommendations to limit resource allocation to those activities that result from the recommendations of the Advisory Council, the Work Groups, and public input received during the planning process. Additionally, the planning activities are consistent with the joint presentation of HSCRC and DHMH to the Health Care Delivery Reform Subcommittee regarding the implementation of the BRFA.

Beginning in late 2013, the HSCRC convened an Advisory Council to develop Guiding Principles for implementation of the new All Payer Model. The Advisory Council put forth its' Final Report on January 31, 2014. The Advisory Council's recommendations were provided to the Commission and to the Work Groups. The recommendations are summarized below:

- Focus on meeting early Model requirements (Note: including through hospitals being on global budgets supported by multi-disciplinary care coordination especially for high-risk Medicare fee-for-service patients, to enable meeting the state-wide ceilings and Medicare savings requirements
- Meet budget targets while making important investments in infrastructure and providing flexibility for private sector innovation
- HSCRC should play the roles of regulator, catalyst and advocate
- Consumers should be involved in planning and implementation
- Physician and other provider alignment is essential
- An ongoing, transparent public engagement process is needed

The HSCRC's focus on care coordination and Alignment in the context of this recommendation is based on the consensus that was achieved through the Advisory Council and multiple Work Groups that these areas should be top priorities, including the potential for shared infrastructure and common approaches. In the Advisory Council meetings, members advised that care coordination is an area where we should focus attention on models that have demonstrated success rather than on many untested and different strategies. The Data and Infrastructure Work Group and

Maryland's Statewide Health Information Exchange, the Chesapeake Regional Information System for our Patients:

Additional HSCRC Funding

Physician Alignment and Engagement Work Group recommended considering shared infrastructure and common approaches to care coordination. Based on this advice, the HSCRC's goal is to facilitate consideration of some shared infrastructure and common approaches that might limit confusion and improve effectiveness for providers and patients.

Infrastructure for care coordination and alignment activities is costly, and there is a need for collaboration across providers and also with community based organizations to ensure patient centeredness and efficiency and effectiveness of processes. There is also a considerable need to utilize sophisticated IT and expert resources for data collection, care plan tools, and analytics, as well as call centers and other resources that might require both collaboration and scale for effectiveness and speed of adoption.

Relative to care coordination, as part of the work plan for implementation, HSCRC recognized that care coordination is an operational effort that will be organized outside of HSCRC. While HSCRC may facilitate the provision of data resources and benchmarks in coordination with vendors, it will not be engaged in an operational role. We envision that consideration of the possible usefulness of some common infrastructure resources can be considered with an intensive planning effort over the next several months. Additional planning efforts might take place in regional and local areas to organize care coordination resources, but these planning efforts would take place through collaborations of hospitals, other providers, payers, and community organizations.

Relative to alignment of hospitals with physicians and other providers, the Physician Engagement and Alignment Work Group made several recommendations aimed to support the success of new All Payer model and lay foundation for future reforms, including efforts to:

- Establish access to care management and coordination tools and resources that can be accessed by hospital and non hospital providers across the state
- Provide standard approaches and consistency in alignment programs with non-hospital providers, including standards in data collection where possible
- Encourage effective scalable approaches to administrative and management resources needed

- Focus initial attention on unmanaged populations (e.g. Medicare fee-for-service and Dual Eligibles)

- Leverage combined resources to acquire needed infrastructure

Specific areas of recommendations included:

- Consider an Integrated Care Network infrastructure that creates a structure to coordinate the care and align financial incentives of different providers to improve care, particularly for the Medicare fee-for-service population in different regions of the State that could support enrollees not already in an ACO or Medicare Advantage plan. Existing ACOs could also make use of the infrastructure. Obtain necessary waivers to support shared savings.

- Expand access to Pay for Performance models that are designed to improve care delivery and care coordination for patients with chronic conditions by providing payments from hospitals to community-based care physicians when quality is improved. Explore additional models with other providers as needed.

- Support the development of a Gain Sharing model by the hospital and physician community to encourage savings for specific services provided in inpatient settings, with leadership of this effort undertaken by the Maryland Hospital Association.

Similar to care coordination, these alignment models and infrastructure would be operationalized outside of HSCRC. Consulting resources will be utilized to develop more specific details and options for consideration by hospitals, physicians, and other stakeholders.

In both cases, the initial efforts will involve planning and further input and consideration by Work Groups and stakeholders relative to further interest in collaboration. Staff estimates that about 40 to 50 percent of the $1 million of consulting funds would be spent on the initial planning efforts. In the event that implementation efforts are not initiated, remaining funds would be used to reduce the FY 2016 CRISP funding support. If implementation proceeds, the remaining funds could be utilized for additional implementation activities.

In summary, staff believes that the dedication of resources for these two activities is consistent with Work Group recommendations and will benefit hospitals by examining opportunities to implement key resource intensive changes in ways that could improve

the effectiveness and efficiency of implementation and also focus on the Triple Aim of the new All Payer Model of better care, better health, and lower cost.

Ongoing Monitoring of CRISP Needs

HSCRC staff and MHCC staff have been discussing the ongoing needs of CRISP as it provides support of the Health Information Exchange and performs work for providers, payers, and other State agencies relative to its mission. CRISP is an important asset in the transformation of the HSCRC's regulatory approaches to population based and patient centered. Major portions of the development work it performs have been supported through grant funding. As resource funding changes, HSCRC, MHCC, and the CRISP staff and board will need to work closely together to assure that this asset is well-maintained and enhanced in light of its ongoing importance to care delivery improvement, regulation, and planning under population based approaches.

Recommendation

HSCRC staff recommends that hospital rates be increased to provide an additional $2 million to CRISP in FY 2015 to support expansion of its current monitoring capacity and engagement of resources to assist (in conjunction with stakeholders) in further evaluation and planning of possible statewide infrastructure and approaches for care coordination and provider alignment.

Staff recommends that amounts spent in planning statewide infrastructure be taken into account when HSCRC considers future approval of infrastructure funding under BRFA. Specifically, the staff recommends that the Commission seek to implement up to $14 million in rate increases to fund BRFA approved activities. One million dollars of the authorized maximum of $15 million will be set aside to support planning and implementation activities under this recommendation. This will result in an amount included in rates that is consistent with the contemplated funding included in the balanced update proposal that was approved by the Commission for FY 2015. If the full $1 million is not expended, staff recommends that any remaining balance be used to reduce the FY 2016 funding requirement of CRISP.

Staff also recommends that a MOU be executed between CRISP and the HSCRC to ensure that requirements are clearly outlined and expenditures monitored in accordance with the MOU.

Maryland's Statewide Health Information Exchange, the Chesapeake Regional Information System for our Patients:

Additional HSCRC Funding

Additionally, staff plans to work with MHCC and the CRISP staff and board to continue to evaluate budget and operational requirements of CRISP.

Maryland
Hospital Association

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

October 9, 2014

Donna Kinzer
Executive Director, Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland

Dear Ms. Kinzer:

On behalf of the 67 member hospitals of the Maryland Hospital Association (MHA), we are writing to comment on the Health Services Cost Review Commission (HSCRC) staff recommendation on *Maryland's Statewide Health Information Exchange, the Chesapeake Regional Information System for our Patients (CRISP): Additional FY 15 HSCRC Funding*. The recommendation describes the unique value CRISP can provide to hospitals and to policymakers in producing data and analyses that leverage the enterprise master patient identifier and recommends increasing hospital rates to support this valuable work. In addition, it recommends using hospital rate funding as authorized by the Budget Reconciliation and Financing Act of 2014 to support the HSCRC Provider Alignment and Care Coordination Work Groups charged with identifying potential shared care management resources and developing strategies that would further align other providers' incentives with those of hospitals under the all-payer demonstration.

MHA seeks to ensure that any hospital rate increases fund only activities that directly contribute to hospitals' ability to carry out their missions in service to their communities. The reports and data sets CRISP has been providing to hospitals and the commission do just that. Hospitals are already finding value in the CRISP readmission reports, which allow them to identify and intervene when patients are readmitted to their own or another hospital. Likewise, the addition of the CRISP enterprise identifier to the HSCRC case-mix data has allowed HSCRC to link current Medicaid beneficiaries with their historical utilization to estimate future uncompensated care reductions with a level of accuracy not previously possible. These types of tools used by hospitals and policymakers add significant value at a very reasonable cost.

MHA recognizes the important and timely role of statewide planning in realizing the health care delivery transformation as envisioned and required under the new waiver agreement and we appreciate the HSCRC's diligence in identifying a suitable funding source to support the work groups charged with these tasks. The Budget Reconciliation and Financing Act of 2014 included three provisions related to hospital rates: it reduced the Maryland Health Insurance Plan assessment funded through hospital rates; required Medicaid savings due to waiver implementation to be netted against the Medicaid deficit assessment; and authorized up to $15 million to be put back into rates to fund state or regional activities that support implementation of the waiver. We believe the work of the HSCRC's Provider Alignment and Care Management Work Groups fulfills the intended purpose of the funding authorized by the Budget Reconciliation and Financing Act. However, we urge caution and additional review before using hospital rates to fund implementation of any work group recommendations.
We appreciate the opportunity to participate in this process and to comment on this recommendation. If you have any questions, please contact me.

Sincerely,

Traci La Valle, Vice President

Donna Kinzer
Executive Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Ms. Kinzer:

On behalf of MedChi and LifeSpan, two organizations that represent key non-hospital stakeholders, we strongly believe that the success of the implementation of the Waiver depends on alignment with post acute care providers and the creation of effective care coordination models across various settings. To assist in the development of these models, we support the Commission's creation of an Alignment and Care Coordination workgroup, including the need to retain outside consultants to assist in addressing key issues surrounding these topics. Therefore, MedChi and LifeSpan support the Commission's request to fund consulting services through rates in order to best achieve this purpose and, ultimately, the goals of the Waiver. If you have any questions, please feel free to contact us. Thank you.

Sincerely,

Gene M Ransom III

Gene Ransom
President and CEO
MedChi

Sincerely,

Isabella Firth
President
LifeSpan

Rate Year 2017 Final Quality Based Reimbursement Recommendation

HSCRC Commission Meeting- 10/15/2014

HSCRC
Health Services Cost Review Commission

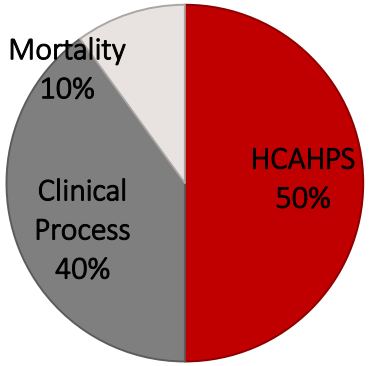
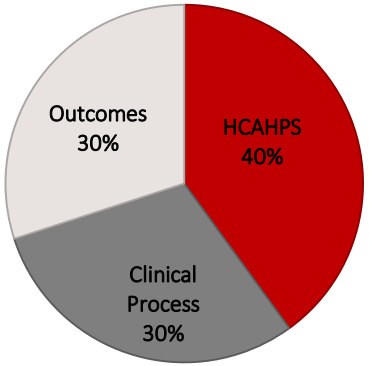
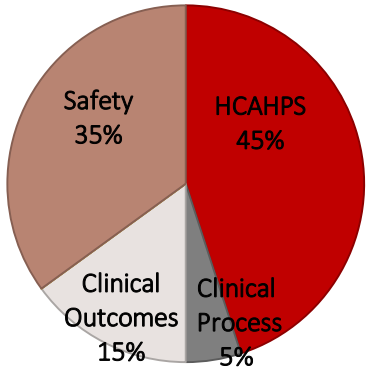
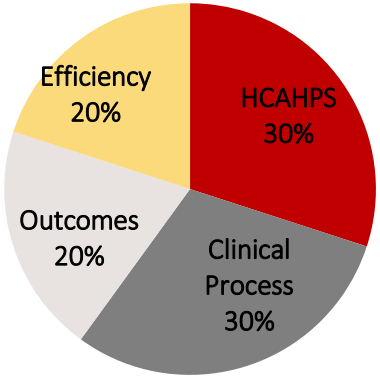
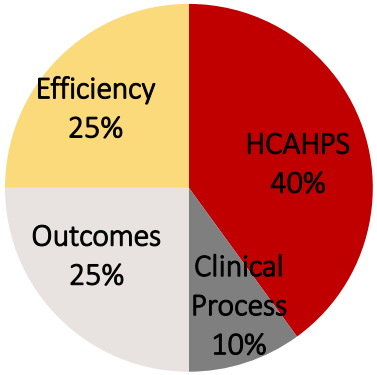
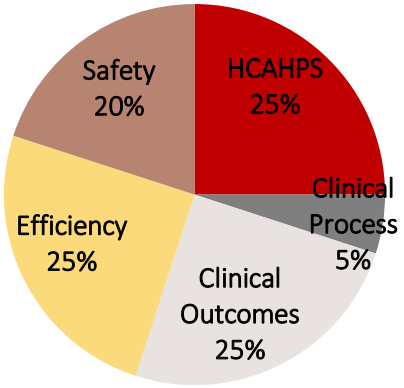
Quality Based Reimbursement (QBR) Program

- The QBR program, implemented in 2010, is analogous to the CMS Value Based Purchasing program (VBP), implemented in 2013.
- Maryland is required to seek exemption from the VBP program by demonstrating cost and quality outcomes equal to or better than the VBP program.

Measure Domain Weighting Recommended for FY 2017

	Clinical • Outcomes (Mortality) • Process	Patient Experience (HCAHPS)	Safety (CAUTI,CLABSI, C.DIFF, SSI, PSI-90)	Efficiency
CMS VBP	• 25 percent • 5 percent	25%	20%	25%
Proposed Maryland QBR	• 15 percent • 5 percent	45%	35%	GBR Adjustments

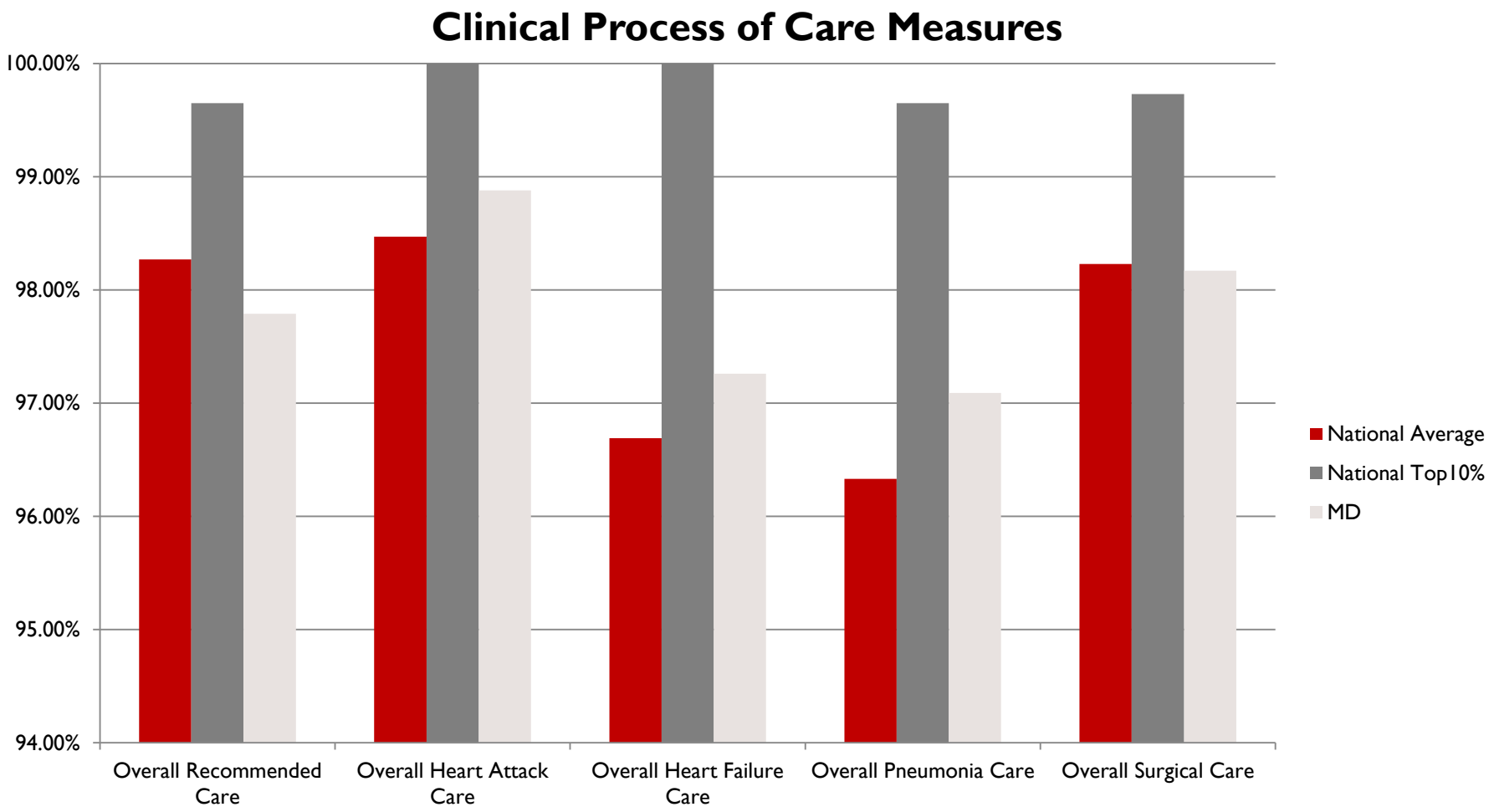
QBR and CMS VBP Domains & Weights Comparison

	FY 15	FY 16	Proposed FY 17
Maryland QBR	0.5% at Risk 	1.0% at Risk 	2.0% at Risk 
CMS VBP Rates	1.5% at Risk 	1.75% at Risk 	2.0% at Risk 

Stakeholder Input

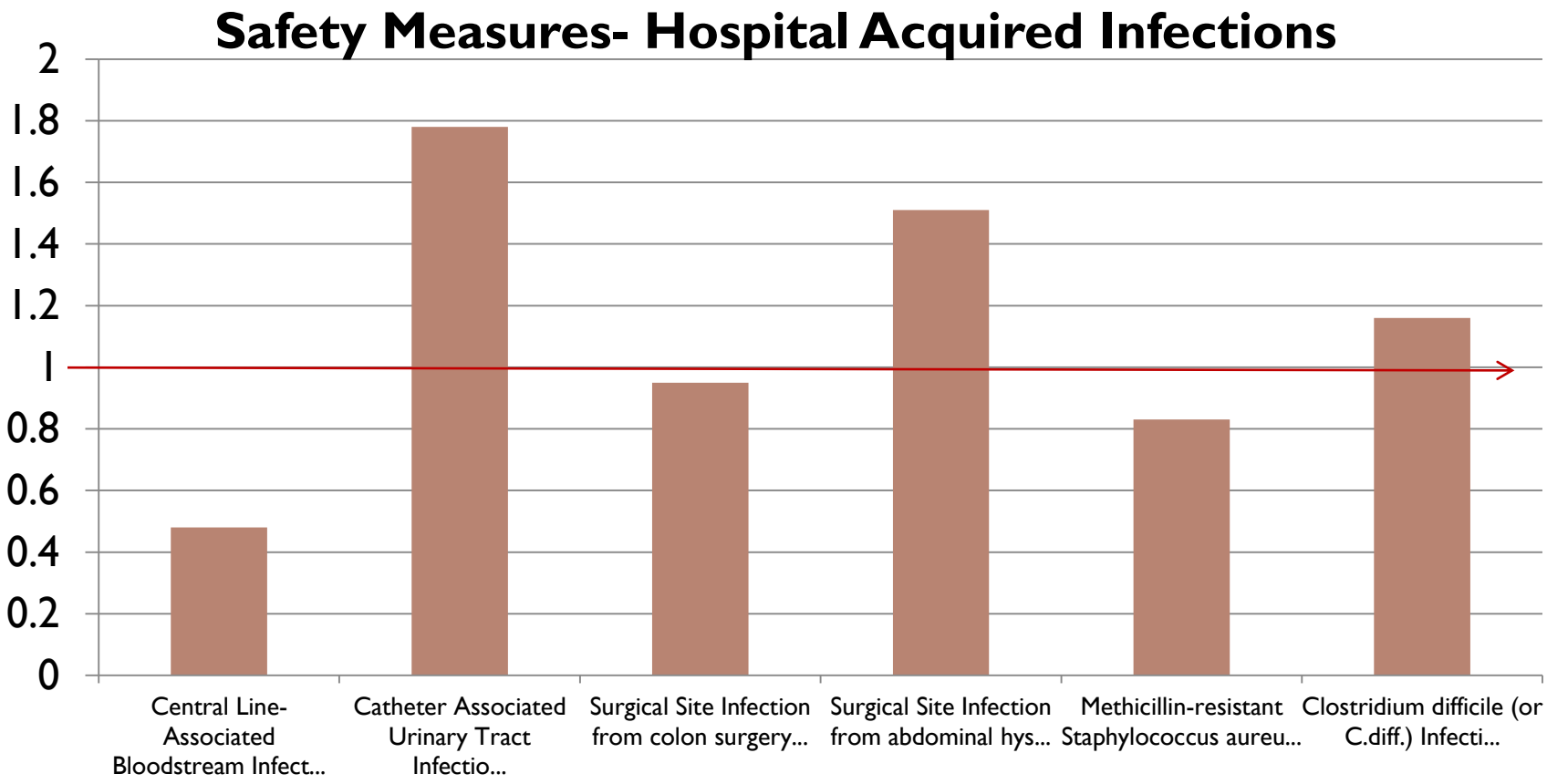
- Performance Work Group discussed the draft in 09/19/2014 meeting
- Staff received a comment letter from MHA representing the hospital industry (Appendix III)
  - Concerns about the magnitude of the percent of revenue at risk increasing for FY 2017 prior to a broader discussion of all the policies that will impact payment for FY 2017.
  - A need for quarterly QBR data by HSCRC to hospitals so hospitals can track the financial impact of the program closer to "real time."
- Staff appreciates this input and will engage in an ongoing discussion with stakeholders on what reporting is feasible beginning in the short term.

Maryland vs. National Benchmarks



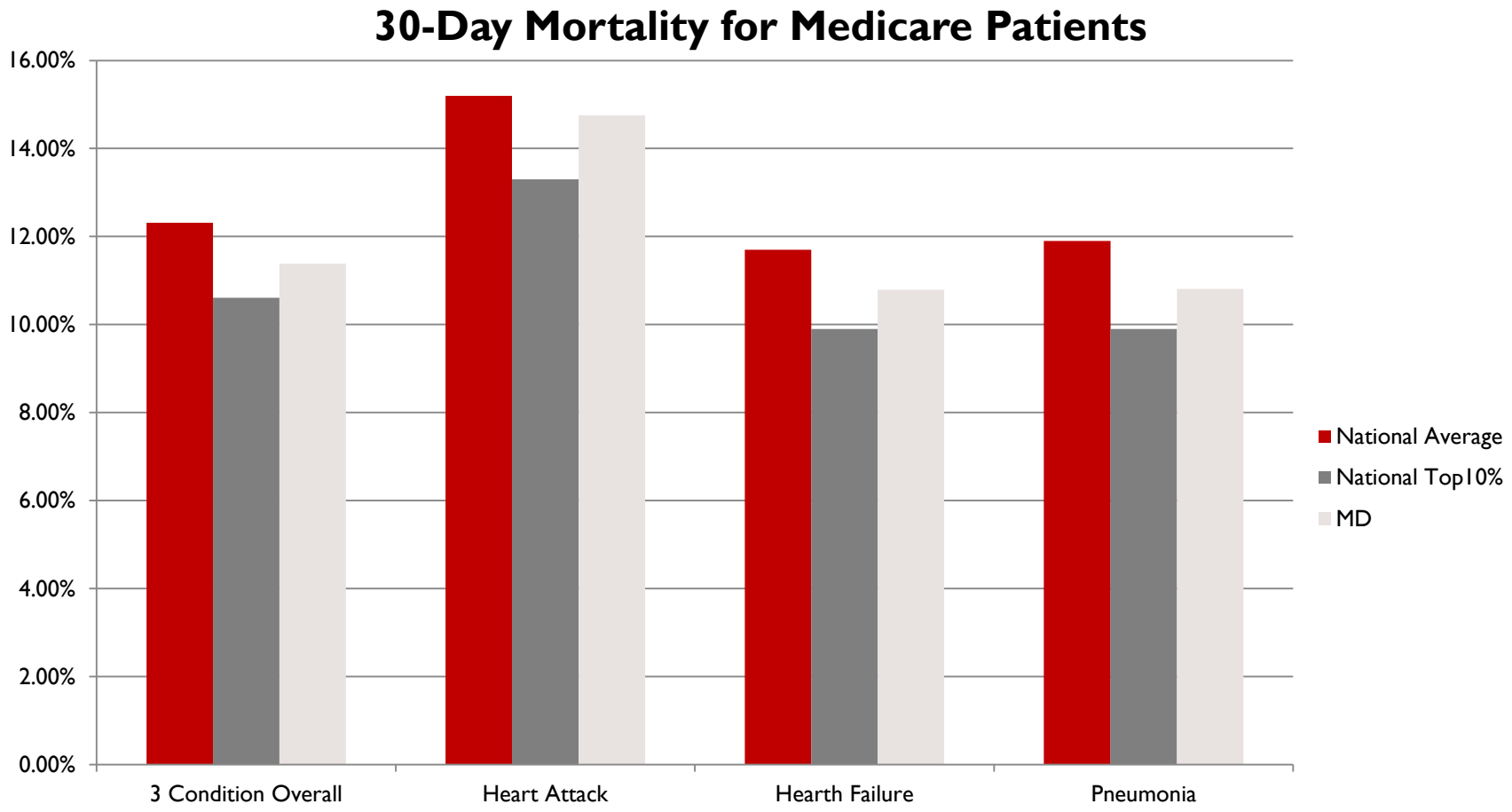
Source: Whynoththebest.com
Data Period: Q4/12-Q3/13

Maryland vs National Benchmark



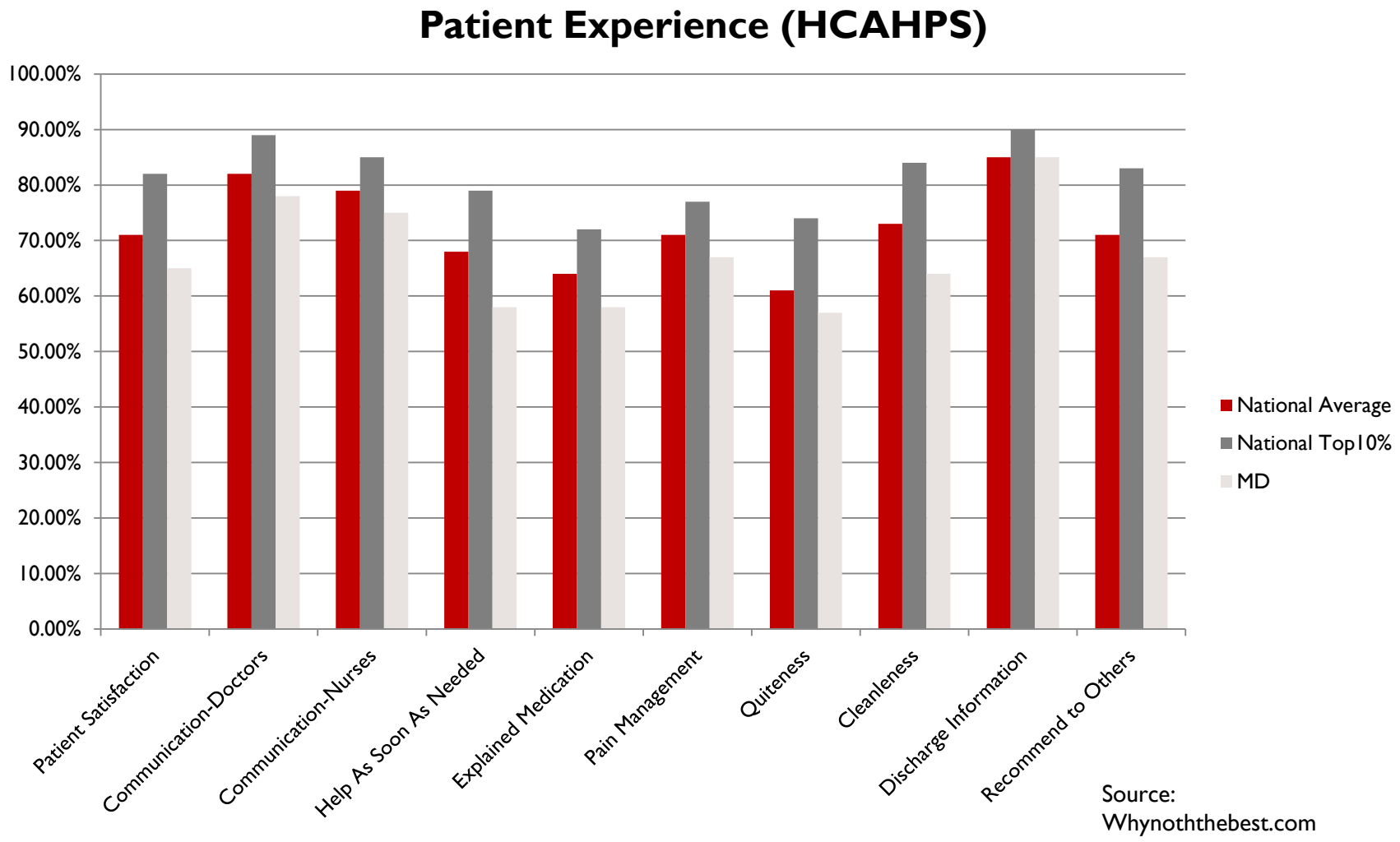
Source: Whynoththebest.com
Data Period: Q4/12-Q3/13

Maryland vs National Benchmarks-



Source:
Whynoththebest.com

Maryland vs. National Benchmarks



Source:
Whynoththebest.com

HCAHPS History, Development, Testing and Endorsement

- HCAHPS is part of the CAHPS suit of standardized surveys; CAHPS was first launched in 1995 to survey quality of health plans (now used in plans with 141,000,000 Americans enrolled)
- Beginning in 2002, CMS partnered with the Agency for Healthcare Research and Quality (AHRQ), to develop and test the HCAHPS Survey-
  - AHRQ and its CAHPS Consortium carried out a rigorous and multi-faceted scientific process, including a public call for measures; literature review; cognitive interviews; consumer focus groups; stakeholder input; a three-state pilot test; extensive psychometric analyses; consumer testing; and numerous small-scale field tests.
  - The CAHPS Consortium :
    - AHRQ, the Centers for Medicare & Medicaid Services (CMS), Centers for Disease Control and Prevention (CDC) and the National Institute for Disability and Rehabilitation Research (NIDRR)
    - RAND, the Yale School of Public Health, and Westat
- In May 2005, the HCAHPS Survey was endorsed by the National Quality Forum
- CMS implemented the HCAHPS Survey in October 2006, and the first public reporting of HCAHPS results occurred in March 2008.

Revenue at Risk of Up to 2% Recommended for QBR FY 2017

- Revenue "at risk" magnitude for QBR should be up to 2% for 2017, contingent upon meeting CMMI requirements for:
  - VBP exemption, and;
  - Total revenue at risk for performance-based payment

- Adjust measurement domain weights to include 5% for process, 15% for outcomes (mortality), 35% for safety, and 45% patient experience of care

Final Recommendation for Updating the Quality Based Reimbursement Program for FY 2017

Health Services Cost Review Commission
4160 Patterson Avenue Baltimore, MD 21215
(410) 764-2605

October 15, 2014

This document contains the final staff recommendations for updating the Quality Based Reimbursement (QBR) Program for FY 2017 for consideration at the October 15, 2014 Public Commission Meeting.

A. Introduction

The HSCRC quality-based measurement initiatives, including the scaling methodologies and magnitudes of revenue "at risk" for these programs, are important policy tools for providing strong incentives for hospitals to improve their quality performance over time. For HCSRC's Quality-based Reimbursement ("QBR") Program, current Commission policy calls for measurement of hospital performance scores across clinical process of care, outcome and patient experience of care domains, and revenue neutral scaling of hospitals in allocating rewards and penalties based on performance.

"Scaling" for QBR refers to the differential allocation of a pre-determined portion of base regulated hospital inpatient revenue based on assessment of the relative quality of hospital performance. The rewards (positive scaled amounts) or penalties (negative scaled amounts) are then applied to each hospital's update factor for the rate year; these scaled amounts are applied on a "one-time" basis (and not considered permanent revenue), and are computed on a "revenue neutral" basis for the system so that the net increases in rates for better performing hospitals are funded entirely by net decreases in rates for poorer performing hospitals.

For the QBR program for State FY 2016 rates, as approved by the Commission, the HSCRC will weight the clinical outcomes domain more heavily than the previous year, and scale a maximum penalty of 1% of approved base hospital inpatient revenue.

Staff recommends adjusting the weights of the measurement domains so that outcome domains account for a greater proportion of the hospital's overall performance scores going forward, as well as updating the amount of total hospital revenue at risk for scaling for the QBR program.

B. Background

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

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 set the reduction at one percent in FY 2013, rising incrementally to 2 percent by FY 2017.

CMS implemented the VBP program with hospital payment adjustments beginning in October 2013. For the federal FY 2016 (October 1, 2015 to September 30, 2016) Hospital VBP program, CMS measures include four domains of hospital performance: clinical process of care; patient experience of care (HCAHPS survey measure); outcomes; and efficiency/Medicare spending per beneficiary. Results are weighted by CMS as listed below, with 1.75% of Medicare hospital payments "at risk" for 2016.

Figure 1. CMS VBP Domain Weights, FY 2016

	Clinical/Process	Patient Experience	Outcome	Efficiency/Medicare spending/beneficiary
FFY 2016	10%	25%	40%	25%

CMS indicated its future emphasis will increasingly lean toward outcomes in the VBP program. In addition, staff notes that for the CMS VBP program for FY 2016, CMS added additional outcome measures, including the Agency for Healthcare Research and Quality ("AHRQ") Patient Safety Indicator ("PSI") 90 Composite measure and the Centers for Disease Control National Health Safety Network ("CDC-NHSN") Central Line Associated Blood Stream Infection (CLABSI) and Catheter Associated Urinary Tract Infection (CAUTI) measure.

2. *QBR Measures, Domain Weighting and Magnitude at Risk to Date*

HSCRC implemented the first hospital payment adjustments for QBR program performance in July 2009. For rate year 2016 (July 1, 2015-June 30, 2016), the QBR program scales 1% of revenue at risk and uses the CMS/Joint Commission core process measures—e.g., aspirin upon arrival for the patient diagnosed with heart attack—, "patient experience of care" or Hospital Consumer Assessment of Healthcare Providers and Systems ("HCAHPS") measures, and three outcome measures, which include AHRQ PSI 90, the CDC-NHSC CLABSI measure, and all-cause inpatient mortality using the 3M Risk of Mortality classifications. The weighting for each domain compared with the CMS VBP Program are illustrated below in Figure 2.

Figure 2. Maryland QBR Compared with CMS VBP Domain Weights, FY 2016

FY 2016	Clinical/ Process	Patient Experience	Outcome	Efficiency
CMS VBP	10%	25%	40%	25%
Maryland QBR	30%	40%	30%	N/A

Staff convened several meetings of the QBR Update Workgroup in October and November of 2013 and the Performance Measurement Workgroup, which began meeting in January 2014, where there was agreement to add measures to be consistent with the VBP Program where feasible, and to align the list of process of care measures, threshold and benchmark values, and time lag periods with those used by CMS, [1] allowing HSCRC to use the data submitted directly to CMS. This alignment must include the measures used, data sources and magnitude of revenue "at risk" for the program. Maryland has not, to date, developed and implemented an efficiency measure as part of the QBR program. As part of the implementation of New All-Payer Model; there was agreement among Workgroup members and staff that a new efficiency measure is needed to incorporate population-based outcomes.

3. *Value Based Purchasing Exemption Provisions*

Pursuant to 1886(o)(1)(C)(iv) of the Social Security Act, "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." VBP exemptions have been requested and granted for FYs 2013, 2014 and 2015.

[1] HSCRC has used core measures data submitted to MHCC and applied state-based benchmarks and thresholds to calculate hospitals' QBR scores up to the period used for State FY 2015 performance.

The CMS FY 2015 Inpatient Prospective Payment final rule states that, in order to implement the Maryland All-Payer Model, CMS has waived certain provisions of the [Social Security] Act, and the corresponding implementing regulations, as set forth in the agreement between CMS and Maryland and subject to Maryland's compliance with the terms of the agreement. The final rule continues that, in other words, although the exemption from the Hospital VBP Program no longer applies, Maryland hospitals will not be participating in the Hospital VBP Program because section 1886(o) of the Act and its implementing regulations have been waived for purposes of the model, subject to the terms of the agreement

The section of Maryland All-Payer Model Agreement between CMS and the State addressing the VBP program is excerpted below.

> **…4. Medicare Payment Waivers.** Under the Model, CMS will waive the requirements of the following provisions of the Act as applied solely to Regulated Maryland Hospitals:
>
> > **…e. Medicare Hospital Value Based Purchasing.** Section 1886(o) of the Act, and implementing regulations at 42 CFR 412.160 - 412.167, only insofar as the State submits an annual report to the Secretary that provides satisfactory evidence that a similar program in the State for Regulated Maryland Hospitals achieves or surpasses the measured results in terms of patient health outcomes and cost savings established under 1886(o) of the Act….

Staff will work out requirements and timelines with CMS for submitting an annual report on comparable programs to the VBP program in the State.

C. Assessment

Staff analyzed changes in performance on the QBR and VBP measures used for FY 2015 performance for Maryland versus the US for October 2012 through September 2013 compared with the immediately prior 12 month period. Figure 3 below lists each of the measures used for the VBP and QBR programs. The data indicate that Maryland improved at a slightly higher rate and/or performed slightly better for all but one of the process of care measures. Maryland also performed significantly better than the US on the CLABSI measure for both time periods and also improved. For HCAHPS, Maryland declined slightly in performance for almost half (4 out of 10) of the measures, and performed below the US on all measures with the exception of "Patient given information about recovery at home" where Maryland improved significantly and now performs the same as the US.

Figure 3. QBR Measures Change for Maryland Versus US

	CLINICAL OUTCOME Mortality						
		MD Base Period	MD Most Current Performance		US Base Period	US Most Current Performance	
		Q308-Q211	Q309-Q212	Difference	Q308-Q211	Q309-Q212	Difference
	Combined CHF, AMI, Pneumonia 30 day mortality	11.56	11.38	-0.18	12.34	12.31	-0.03
	CLINICAL PROCESS						
		Maryland Base Period	MD Performance Period		US Base Period	US Performance Period	
		Oct 11-Sep12	Oct12-Sep13	Difference	Oct11-Sep12	Oct12-Sep13	Difference
AMI 8a	Primary PCI within 90 minutes	89.96	94.68	4.72	95.22	96.25	1.03
HF 1	Discharge instructions	92.94	94.28	1.34	92.59	93.9	1.31
IMM 1	Pneumococcal vaccination*	91.59	94	2.41	88.28	92	3.72
Imm 2	Influenza vaccination*	90.19	94	3.81	84.16	90	5.84
PN 3b	Blood culture before first antibiotic	96.53	97.03	0.5	96.93	97.4	0.47
PN 6	Initial antibiotic selection	95.82	97.29	1.47	94.63	95.19	0.56
SCIP INF 1	Antibiotic givin within 1 hour	97.79	97.7	-0.09	97.96	98.3	0.34
SCIP INF 4	Cardiac surgery patients with controlled 6am postop serum glucose	94.23	96.51	2.28	95.88	96.47	0.59
SCIP INF 9	Urinary catheter removed postop day 1 or 2	93.69	97.74	4.05	94.98	96.84	1.86
Clinical Process	***Average Total Score***	93.64	95.91	2.28	93.40	95.15	1.75
	PATIENT EXPERIENCE (HCAHPS)						
HCAHPS	Doctors always communicated well	77.51	78	0.49	81.34	82	0.66
HCAHPS	Nurses always communicated well	74.84	75	0.16	78.18	79	0.82
HCAHPS	Patients always received help as soon as they wanted	59.19	58	-1.19	66.63	68	1.37
HCAHPS	Staff explained about medication	59.02	58	-1.02	63.47	64	0.53
HCAHPS	Pain was always controlled	67.67	67	-0.67	70.63	71	0.37
HCAHPS	Patient room always kept quiet	56.05	57	0.95	60.35	65	4.65
HCAHPS	Patient room always kept clean	65.21	64	-1.21	72.78	73	0.22
HCAHPS	Patient given information about recovery at home	82.93	85	2.07	84.21	85	0.79
HCAHPS	Patient would definitely recommend hospital to friends and family	66.88	67	0.12	70.76	71	0.24
HCAHPS	***Average Total Score***	***67.70***	***67.67***	***-0.03***	***72.04***	***73.11***	***1.07***
	SAFETY**						
		MD Base Period	MD Most current performance	Difference	US Base Peroid	US Most current performance	Difference
	CLABSI	0.55	0.53	-0.02	1	1	N/A
	CAUTI	1.59	1.78	0.19	1	1	N/A
	MRSA	N/A	1.83	N/A	N/A	1	N/A
	C-diff	N/A	1.16	N/A	N/A	1	N/A
	SSI Colon	N/A	0.95	N/A	N/A	1	N/A
	SSI Hysterectomy	N/A	1.51	N/A	N/A	1	N/A
	PSI 90	Data Unavailable			Data Unavailable		
*Data collection periods for Immunization measures differ than those for other measures.							
**For the Safety measures are ratios where a decrease indicates improvement. An average score for the saferty domain was not calculated due to incomplete data.							

Staff examined measures finalized for the CMS VBP Program for FY 2017 in the 2015 CMS Inpatient Prospective Payment System (IPPS) Final Rule and those in the potential pool for the QBR program for 2017. Figure 4 below details the measures by domain and the available published performance standards for each measure, and indicates the measures that will be included in the VBP and QBR programs.

Figure 4. Measures and Performance Standards for the FY 2017 CMS Hospital VBP Program Compared with Maryland QBR Program

Measure ID (Applicable Programs)	Description	Achievement Threshold	Benchmark
Safety Measures			
CAUTI **(VBP and New QBR)**	Catheter-Associated Urinary Tract Infection	0.845	0.000
CLABS **(VBP and QBR)**	Central Line-Associated Blood Stream Infection	0.457	0.000
C. *difficile* **(New VBP and QBR TBD- MD data collection began in July 2013.)**	*Clostridium difficile* Infection	0.750	0.000
MRSA Bacteremia **(New VBP and QBR TBD- MD data collection began in July 2013)**	Methicillin-Resistant *Staphylococcus aureus* Bacteremia	0.799	0.000
PSI-90 **(VBP and QBR)**	Complication/patient safety for selected indicators (composite)	0.577321* **(*VBP MEDICARE ONLY;QBR All-PAYER THRESHOLD TBD)**	0.397051* **(*VBP MEDICARE ONLY;QBR All-PAYER BENCHMARK TBD)**
SSI **(VBP and New QBR)**	Surgical Site Infection • Colon • Abdominal Hysterectomy	• 0.751 • 0.698	• 0.000 • 0.000
Clinical Care – Outcomes Measures			
MORT-30-AMI **(VBP ONLY)**	Acute Myocardial Infarction (AMI) 30-day mortality rate	0.851458	0.871669
MORT-30-HF **(VBP ONLY)**	Heart Failure (HF) 30-day mortality rate	0.881794	0.903985
MORT-30-PN **(VBP ONLY)**	Pneumonia (PN) 30-day mortality rate	0.882986	0.908124
Mortality **(QBR ONLY)**	All-cause inpatient using 3M risk of mortality	TBD	TBD
Clinical Care – Process Measures			
AMI-7a **(VBP and QBR)**	Fibrinolytic Therapy Received Within 30 Minutes of Hospital Arrival	0.954545	1.000000
IMM-2 **(VBP and QBR)**	Influenza Immunization	0.951607	0.997739

Measure ID (Applicable Programs)	Description	Achievement Threshold	Benchmark
PC-01 **(New VBP and QBR TBD- MD data collection began in January 2014)**	Elective Delivery Prior to 39 Completed Weeks Gestation	0.031250	0.000000
Efficiency and Cost Reduction Measure			
MSPB-1 **(VBP ONLY)**	Medicare Spending per Beneficiary	Median Medicare Spending per Beneficiary ratio across all hospitals during the performance period	Mean of the lowest decile Medicare Spending per Beneficiary ratios across all hospitals during the performance period

Patient and Caregiver-Centered Experience of Care/Care Coordination Domain			
HCAHPS Survey Dimension (VBP and QBR)	**Floor (percent)**	**Achievement Threshold (percent)**	**Benchmark (percent)**
Communication with Nurses	58.14	78.19	86.61
Communication with Doctors	63.58	80.51	88.80
Responsiveness of Hospital Staff	37.29	65.05	80.01
Pain Management	49.53	70.28	78.33
Communication about Medicines	41.42	62.88	73.36
Hospital Cleanliness & Quietness	44.32	65.30	79.39
Discharge Information	64.09	85.91	91.23
Overall Rating of Hospital	35.99	70.02	84.60

Staff is proposing updated measure domain weights based on the VBP measures domain weights published in the CMS IPPS Final Rule, Maryland's need to improve on the HCAHPS measures, and the measures and domains available for adoption in the QBR rate year FY 2017; Figure 4 below illustrates the VBP final domain weights and the QBR proposed domain weights.

Staff circulated the draft recommendation via email to the members of the Performance Measurement Workgroup as in person meetings were not feasible due to summer schedules. The draft recommendation will be discussed at the September 19 in person meeting and issues raised in the discussions will be incorporated into the final recommendation.

Figure 4. Final Measure Domain Weights for the Hospital VBP Program and Proposed Domain Weights for the QBR Program FY 2017

	Clinical • Outcomes (Mortality) • Process	Patient Experience	Safety	Efficiency
CMS VBP	• 25 percent • 5 percent	25%	20%	25%
Proposed Maryland QBR	• 15 percent • 5 percent	45%	35%	N/A

Staff notes again that the established revenue "at risk" magnitude for the CMS VBP Program is set at 2% for 2017. To determine the potential impact of increasing the amount of revenue at risk for the QBR program to 1.5% versus 2%, staff used the most recent scaling results (October 1, 2012 to September 30, 2013 performance period) that apply to hospitals for rate year FY 2015 for modeling purposes. The results, to be considered for altering the magnitude of revenue to be scaled for rate year FY 2017, detailed in Appendix I, reveal that a total range of $7.7M to $10.3M is redistributed under the revenue neutral scaling methodology.

Staff received a comment letter from MHA representing the hospital industry (Appendix III) to the draft recommendation presented last month raising concerns about the magnitude of the percent of revenue at risk increasing for FY 2017 prior to a broader discussion of all the policies that will impact payment for FY 2017. MHA also raised concerns about the need for quarterly QBR data by HSCRC to hospitals so hospitals can track the financial impact of the program closer to "real time." Staff appreciates this input and will engage in an ongoing discussion with stakeholders on what reporting is feasible beginning in the short term.

A memo summarizing the updates to the QBR methodology with the required benchmark data will be sent to the hospitals after final Commission approval of the QBR program updates for FY 2017.

D. Recommendations

For the QBR program, staff provides the following recommendation:

1. Allocate up to 2% of hospital approved inpatient revenue for QBR relative performance in FY 2017.
2. The precise percent at risk allocated for the QBR program will be determined by the end of CY 2014 and will entail broader stakeholder discussion and subsequent Commission action about percentage of revenue at risk for the performance-based payment policies as a whole, and will be contingent upon feedback from and compliance with CMMI under the All-payer Model.
3. Adjust measurement domain weights to include 5% for process, 15% for outcomes (mortality), 35% for safety, and 45% patient experience of care.

Appendix I. QBR Continuous Linear Scaling- Modeling Maximum Penalty of 1.5% Versus 2% of Hospital Inpatient Revenue Using Data Results for RY 2015

HOSPID	HOSPITAL NAME	INPATIENT REVENUE	QBR FINAL POINTS	SCALING BASIS 1.5%	SCALING BASIS 2%	REVENUE IMPACT OF SCALING 1.5%	REVENUE IMPACT OF SCALING 2%	REVENUE NEUTRAL ADJUSTED REVENUE IMPACT OF SCALING 1.5%	REVENUE NEUTRAL ADJUSTED REVENUE IMPACT OF SCALING 2%	REVENUE NEUTRAL ADJUSTED GROSS REVENUE 1.5%	REVENUE NEUTRAL ADJUSTED GROSS REVENUE 2%	REVENUE NEUTRAL ADJUSTED PERCENT 1.5%	REVENUE NEUTRAL ADJUSTED PERCENT 2%
A	B	C	D	E	F	G	H	I	J	K	L	M	N
210062	Southern Maryland Hospital Center	$ 159,227,525	0.050	-1.500%	-2.000%	-$2,388,413	-$3,184,551	-$2,388,413	-$3,184,551	$156,839,112	$156,042,975	-1.500%	-2.000%
210003	Prince Georges Hospital Center	$ 172,920,161	0.110	-1.253%	-1.671%	-$2,167,170	-$2,889,561	-$2,167,170	-$2,889,561	$170,752,991	$170,030,601	-1.253%	-1.671%
210048	Howard County General Hospital	$ 163,303,899	0.230	-0.760%	-1.013%	-$1,240,839	-$1,654,452	-$1,240,839	-$1,654,452	$162,063,061	$161,649,448	-0.760%	-1.013%
210013	Bon Secours Hospital	$ 76,305,158	0.251	-0.675%	-0.900%	-$514,792	-$686,390	-$514,792	-$686,390	$75,790,366	$75,618,769	-0.675%	-0.900%
210019	Peninsula Regional Medical Center	$ 228,027,801	0.269	-0.600%	-0.800%	-$1,367,997	-$1,823,995	-$1,367,997	-$1,823,995	$226,659,805	$226,203,806	-0.600%	-0.800%
210044	Greater Baltimore Medical Center	$ 196,617,898	0.279	-0.560%	-0.747%	-$1,101,266	-$1,468,354	-$1,101,266	-$1,468,354	$195,516,632	$195,149,544	-0.560%	-0.747%
210029	Johns Hopkins Bayview Medical Center	$ 347,704,294	0.285	-0.534%	-0.712%	-$1,855,601	-$2,474,135	-$1,855,601	-$2,474,135	$345,848,693	$345,230,159	-0.534%	-0.712%
210055	Laurel Regional Hospital	$ 75,611,683	0.294	-0.495%	-0.661%	-$374,653	-$499,537	-$374,653	-$499,537	$75,237,030	$75,112,146	-0.495%	-0.661%
210060	Fort Washington Medical Center	$ 17,342,569	0.295	-0.493%	-0.657%	-$85,421	-$113,895	-$85,421	-$113,895	$17,257,148	$17,228,674	-0.493%	-0.657%
210022	Suburban Hospital	$ 176,985,550	0.310	-0.431%	-0.574%	-$762,580	-$1,016,774	-$762,580	-$1,016,774	$176,222,969	$175,968,776	-0.431%	-0.574%
210001	Meritus Hospital	$ 182,862,924	0.310	-0.431%	-0.574%	-$787,904	-$1,050,539	-$787,904	-$1,050,539	$182,075,019	$181,812,385	-0.431%	-0.574%
210040	Northwest Hospital Center	$ 138,718,749	0.316	-0.407%	-0.543%	-$565,094	-$753,459	-$565,094	-$753,459	$138,153,654	$137,965,289	-0.407%	-0.543%
210057	Shady Grove Adventist Hospital	$ 223,152,951	0.320	-0.390%	-0.520%	-$869,741	-$1,159,655	-$869,741	-$1,159,655	$222,283,210	$221,993,296	-0.390%	-0.520%
210018	Montgomery General Hospital	$ 85,514,349	0.335	-0.328%	-0.437%	-$280,547	-$374,063	-$280,547	-$374,063	$85,233,802	$85,140,286	-0.328%	-0.437%
210011	St. Agnes Hospital	$ 233,289,323	0.335	-0.328%	-0.437%	-$765,354	-$1,020,472	-$765,354	-$1,020,472	$232,523,969	$232,268,851	-0.328%	-0.437%
210015	Franklin Square Hospital Center	$ 278,723,093	0.345	-0.287%	-0.383%	-$799,797	-$1,066,396	-$799,797	-$1,066,396	$277,923,296	$277,656,697	-0.287%	-0.383%
210037	Memorial Hospital at Easton	$ 92,515,251	0.364	-0.208%	-0.277%	-$192,111	-$256,149	-$192,111	-$256,149	$92,323,139	$92,259,102	-0.208%	-0.277%
210016	Washington Adventist Hospital	$ 157,754,799	0.367	-0.196%	-0.261%	-$308,512	-$411,350	-$308,512	-$411,350	$157,446,287	$157,343,450	-0.196%	-0.261%
210024	Union Memorial Hospital	$ 236,590,732	0.374	-0.166%	-0.221%	-$392,446	-$523,262	-$392,446	-$523,262	$236,198,286	$236,067,471	-0.166%	-0.221%
210033	Carroll Hospital Center	$ 134,838,320	0.380	-0.143%	-0.191%	-$192,858	-$257,144	-$192,858	-$257,144	$134,645,462	$134,581,176	-0.143%	-0.191%
210004	Holy Cross Hospital	$ 311,801,309	0.400	-0.061%	-0.081%	-$189,539	-$252,719	-$189,539	-$252,719	$311,611,770	$311,548,590	-0.061%	-0.081%
210056	Good Samaritan Hospital	$ 176,449,767	0.405	-0.040%	-0.054%	-$70,983	-$94,644	-$70,983	-$94,644	$176,378,785	$176,355,124	-0.040%	-0.054%
210061	Atlantic General Hospital	$ 37,698,304	0.426	0.048%	0.064%	$18,052	$24,069	$12,462	$16,616	$37,710,766	$37,714,920	0.033%	0.044%
210012	Sinai Hospital	$ 418,687,491	0.446	0.127%	0.169%	$529,804	$706,406	$365,751	$487,668	$419,053,243	$419,175,160	0.087%	0.116%
210038	Maryland General Hospital	$ 130,524,694	0.451	0.148%	0.197%	$192,860	$257,147	$133,141	$177,522	$130,657,835	$130,702,215	0.102%	0.136%
210035	Civista Medical Center	$ 74,476,146	0.455	0.165%	0.220%	$123,164	$164,218	$85,026	$113,368	$74,561,172	$74,589,514	0.114%	0.152%
210034	Harbor Hospital Center	$ 120,977,775	0.469	0.221%	0.295%	$267,581	$356,775	$184,725	$246,300	$121,162,500	$121,224,075	0.153%	0.204%
210032	Union of Cecil	$ 66,197,257	0.482	0.277%	0.369%	$183,360	$244,480	$126,583	$168,777	$66,323,840	$66,366,034	0.191%	0.255%
210002	University of Maryland Hospital	$ 842,774,096	0.484	0.284%	0.379%	$2,394,842	$3,193,122	$1,653,283	$2,204,377	$844,427,379	$844,978,473	0.196%	0.262%
210039	Calvert Memorial Hospital	$ 65,741,743	0.491	0.315%	0.420%	$207,196	$276,261	$143,038	$190,717	$65,884,781	$65,932,461	0.218%	0.290%
210049	Upper Chesapeake Medical Center	$ 145,284,971	0.495	0.330%	0.440%	$479,229	$638,972	$330,837	$441,116	$145,615,808	$145,726,087	0.228%	0.304%
210043	Baltimore Washington Medical Center	$ 217,712,318	0.495	0.330%	0.440%	$718,134	$957,512	$495,765	$661,020	$218,208,083	$218,373,338	0.228%	0.304%
210005	Frederick Memorial Hospital	$ 184,859,281	0.500	0.350%	0.467%	$647,774	$863,699	$447,192	$596,256	$185,306,473	$185,455,537	0.242%	0.323%
210030	Chester River Hospital Center	$ 28,699,194	0.539	0.509%	0.679%	$146,086	$194,781	$100,851	$134,467	$28,800,045	$28,833,662	0.351%	0.469%
210051	Doctors Community Hospital	$ 132,902,820	0.540	0.515%	0.687%	$684,311	$912,415	$472,416	$629,887	$133,375,236	$133,532,708	0.355%	0.474%
210010	Dorchester General Hospital	$ 24,515,059	0.552	0.563%	0.751%	$137,989	$183,986	$95,261	$127,015	$24,610,320	$24,642,073	0.389%	0.518%
210027	Western MD Regional Medical Center	$ 179,984,650	0.589	0.718%	0.957%	$1,291,486	$1,721,982	$891,580	$1,188,773	$180,876,229	$181,173,423	0.495%	0.660%
210008	Mercy Medical Center	$ 227,476,677	0.609	0.799%	1.065%	$1,816,689	$2,422,252	$1,254,154	$1,672,206	$228,730,831	$229,148,882	0.551%	0.735%
210017	Garrett County Memorial Hospital	$ 18,267,389	0.611	0.806%	1.074%	$147,177	$196,236	$101,604	$135,472	$18,368,993	$18,402,861	0.556%	0.742%
210023	Anne Arundel Medical Center	$ 302,553,244	0.615	0.823%	1.098%	$2,490,917	$3,321,222	$1,719,608	$2,292,811	$304,272,852	$304,846,055	0.568%	0.758%
210006	Harford Memorial Hospital	$ 45,941,091	0.632	0.894%	1.192%	$410,619	$547,492	$283,472	$377,962	$46,224,563	$46,319,053	0.617%	0.823%
210009	Johns Hopkins Hospital	$ 1,260,991,141	0.634	0.900%	1.200%	$11,344,725	$15,126,300	$7,831,850	$10,442,466	$1,268,822,991	$1,271,433,607	0.621%	0.828%
210028	St. Mary's Hospital	$ 67,824,688	0.698	1.164%	1.552%	$789,483	$1,052,644	$545,021	$726,694	$68,369,709	$68,551,383	0.804%	1.071%
	Statewide Total	**$8,460,348,137**				**$7,747,859**	**$10,330,478**	**$ (0.0)**	**$ (0.0)**	**$ 8,460,348,137**	**$ 8,460,348,137**	**-0.1%**	**-0.1%**

Appendix II. QBR Measurement Periods

HSCRC Quality Program Measurement, Performance and Impact Periods																				
Rate Year (Maryland Fiscal Year)		FY13-Q2	FY13-Q3	FY13-Q4	FY14-Q1	FY14-Q2	FY14-Q3	FY14-Q4	FY15-Q1	FY15-Q2	FY15-Q3	FY15-Q4	FY16-Q1	FY16-Q2	FY16-Q3	FY16-Q4	FY17-Q1	FY17-Q2	FY17-Q3	FY17-Q4
Calendar Year		CY12-Q4	CY13-Q1	CY13-Q2	CY13-Q3	CY13-Q4	CY14-Q1	CY14-Q2	CY14-Q3	CY14-Q4	CY15-Q1	CY15-Q2	CY15-Q3	CY15-Q4	CY16-Q1	CY16-Q2	CY16-Q3	CY16-Q4	CY17-Q1	CY17-Q2
Quality Programs that Impact Rate Year 2017																				
QBR			Federal Base: Core, HCAHPS, Safety (HAI)														Rate Year Impacted by QBR Results			
										QBR Core, HCAHPS , Safety (HAI) Performance Period										
					Maryland Base: Mortality, Safety (PSI -90)															
											Mortality, PSI-90 Performance Period									

Maryland
Hospital Association

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September 22, 2014

Donna Kinzer
Executive Director, Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland

Dear Ms. Kinzer:

On behalf of the 67 members of the Maryland Hospital Association (MHA), we appreciate the opportunity to comment on the proposed changes to the Quality Based Reimbursement (QBR) program. We would like to thank Health Services Cost Review Commission (HSCRC) staff for their consideration of MHA's feedback before releasing the draft recommendation. After we disseminated the draft recommendation within the field, the following concerns were raised:

Amount at Risk
As part of the Maryland all-payer demonstration agreement, the amount at risk to hospitals for quality programs in the aggregate must be commensurate with the aggregate amount at risk under the national hospital prospective payment system. In fiscal year 2016, the aggregate amount at risk was 5.75 percent; in fiscal year 2017, the aggregate amount at risk is 6 percent. It is important to remember that the amount at risk nationally applies to a hospital's Medicare base payment, not the full Medicare payment. As a result, the national aggregate amount at risk is 6 percent of a portion of a hospital's Medicare revenue. In Maryland, the aggregate amount at risk is 6 percent of the hospital's entire revenue base.

HSCRC staff proposes to increase the amount at risk for QBR to 2.0 percent, the same percentage at risk in the national Value Based Purchasing (VBP) program. This follows an increase in the Maryland QBR from 0.5 percent to 1 percent for rate year 2016. To propose another doubling of the amount at risk for a program not directly tied to the readmissions and complications metrics under the waiver agreement is causing great concern.

Maryland's QBR program results are strongly influenced by two controversial measures: inpatient mortality, the preponderance of which occurs during zero and one day-stays; and patient experience of care, a subjective measure that is geographically biased and difficult to improve. Maryland's lack of a hospital-level "efficiency metric" similar to the Medicare Spending per Beneficiary metric included in the national VBP program should not be criticized, since the per capita waiver demonstration agreement holds the entire state to a rigorous efficiency standard. This absence causes Maryland's program to put additional weight on the remaining metrics. To address these issues, **MHA proposes that the QBR amount at risk remain at 1 percent until the fiscal year 2017 amounts at risk for all other Maryland quality-related programs can be decided**.

Access to Data
MHA appreciates staff's commitment to routinely send data to Maryland's hospitals so hospitals can monitor their progress and project the resulting payment impacts under the Maryland Hospital Acquired Conditions and readmissions programs. We understand that HSCRC staff is open to, and we look forward to working with HSCRC and MHCC staff on, **a process whereby hospitals can receive quarterly data to estimate their performance and resulting payment impact under the QBR program**.

-more-

Interim results are particularly important under the QBR program because the payment adjustments are based on a hospital's position relative to other hospitals in the state; a hospital must know not only their own results, but the results of every other hospital in the state to project their expected payment adjustment. Because the QBR program includes metrics calculated using HSCRC-collected data and data collected by Medicare contractors, producing interim results is more complicated than producing interim complications and readmissions results. However, we believe a small group of technical experts can find a workable solution. We appreciate the HSCRC and MHCC's willingness to develop a solution.

Thank you for the opportunity to participate in this process and to comment on this recommendation. If you have any questions, please contact me.

Sincerely,

Traci La Valle
Vice President

Chet Burrell
President and Chief Executive Officer

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October 10, 2014

John M. Colmers
Chairman, Health Services Cost Review Commission
4201 Patterson Avenue
Baltimore, Maryland 21215

Donna Kinzer
Executive Director, Health Services Cost Review Commission
4201 Patterson Avenue
Baltimore, Maryland 21215

Re: Final Recommendation for Updating the Quality Based Reimbursement (QBR) Program for FY2017

Dear Mr. Colmers and Ms. Kinzer:

Thank you for this opportunity to provide comments on the Staff's Final Recommendation for Updating the HSCRC's Quality Based Reimbursement (QBR) Policy for FY 2017. I know we all see this as critical since, under the terms of the new Demonstration Waiver, the HSCRC is now required to demonstrate it is successfully incenting Maryland hospitals to improve their outcomes, process of care, patient experience, patient safety and efficiency domains and otherwise be in alignment with the Value Based Payment (VBP) program implemented by the Centers for Medicare and Medicaid Services (CMS) for hospitals nationally.

As discussed in the staff presentation accompanying the recommendation, the HCAHPS survey has a long track record and has been validated by national quality organizations and the Agency of Healthcare Quality and Research (AHRQ). It is, therefore, an important tool for measuring overall patient satisfaction and experience of care.

We would note that the overall percentage of hospital inpatient revenue at-risk in Maryland for the QBR has been below the percentage of hospital inpatient revenue at-risk imposed by CMS for hospitals nationally under its VBP program.[1] Given the very strong incentives facing hospitals under Global Budget Rate arrangements to reduce service utilization and cost, it is extremely important to have strong complementary financial incentives to maintain or improve clinical quality, patient safety, patient satisfaction and outcomes.

[1] For instance, the percent of revenue at-risk for these quality-based measures as follows: 0.5% for Maryland vs. 1.0% nationally in FY15 and 1.0% for Maryland vs. 1.5% nationally in FY16. In FY 17 CMS has indicated it will increase the percentage of hospital inpatient revenue at risk under the VBP nationally to 2.0%.

In light of these considerations, CareFirst supports the Staffs' recommended changes to the QBR program including increasing the percentage of inpatient revenue at risk to 2.0% in FY17 commensurate with the percentage of at-risk revenue imposed by CMS on hospitals nationally. We believe the Staff's recommendations will better align the structure and weighting of the Maryland program with CMS's VBP, provide stronger overall incentives to encourage Maryland hospital performance improvement and satisfy the performance-based payment policies under the demonstration agreement.

Although the final at-risk percentage for the QBR will be formulated later this year (in the context of other requirements under the new waiver) it is critical to ensure that the final amount of hospital revenue at risk for QBR meet the standards specified in the CMS agreement.

As always, we sincerely appreciate the work of the Staff and the Commission that supports the development and implementation of these important programs.

Sincerely,

Chet Burrell
President and CEO

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October 8, 2014

Donna Kinzer
Executive Director, Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Thank you for the opportunity to comment on the "Draft Recommendation for Updating the Quality Based Reimbursement Program for FY2017".

We are supportive of making changes to increase the amount of risk amount related to Quality Based Reimbursement ("QBR") Program . We believe these changes should be made to align better with CMS and should take into consideration the total amount of risk of all quality-based programs.

Since Maryland's waiver takes into account efficiency metrics and there most likely will be separate policies developed to determining a Hospital's efficiency, we believe the 2.0% should be adjusted to 1.5% for removal of efficiency. We additionally believe the weighting factors should be as close to CMS as possible. We propose the following:

		Mortality Process	Patient Experience	Safety
CMS VBP	2.00%	30%	25%	20%
Weighting adjusted for efficiency	25%	40%	33%	27%
$ adjusted for efficiency	1.50%	0.60%	0.50%	0.40%

While we know Maryland is doing worse in patient experience then the rest of the country, there are no concrete measures to improve this outcome. There are many programs and methods, but a lot depends on the socioeconomic dynamics that are specific to the population served. We want to make sure we

invest resources where we can show measureable improvement/better outcomes for our patients. Therefore, we believe patient experience should be weighted lower.

Additionally, we believe if we increase the percentages at risk for the QBR, then the Maryland Hospital Acquired Conditions and the Readmissions Programs percentages at risk should be adjusted downward. In total, we should not exceed the CMS percentages at risk. Additionally in developing these percentages, we should factor that Maryland's percentage is on an all payor and includes all payments, which defers from the Medicare Program, which is Medicare only and only includes Medicare's base payment . As a %, Maryland's dollars at risk our much higher than CMS's Quality Program.

Thank you for allowing us to comment. Please feel free to contact us should you have any questions.

Sincerely,

Chris Goeschel

Chris Goeschel
AVP Quality

Kathy Talbot

Kathy Talbot
VP of Rates and Reimbursement

Update on Global Budgets and Work Groups

- GBR Transfers Adjustments
- GBR Market Share Adjustments
- Performance and Payment Work Group Schedules

GBR Transfer Adjustments Recap

- Payment Models Work Group and Transfer Subgroup meetings in June, July, August and September
- Focused on ensuring access to care for complex cases and patient protections
- Worked to develop transfer cases payment adjustments to GBR revenues based on variation from the baseline transfer rates to academic medical centers (AMCs)

Transfer Definitions

- Transfers to University of Maryland Medical Center (UMMC) and Johns Hopkins University Hospital (JHH)
- Transfers from Inpatient and Emergency Departments
- Admission to AMCs within one day
- Exclusions
  - Categorical cases (transplants, research, burn etc)
  - Out of state patients
  - MDC-5 (Cardiology and cardiac surgery), psychiatric DRGs, and Rehabilitation DRGs

GBR Transfer Adjustments

- AMC adjustments
  - Quarterly adjustment to budget based on rate of change compared to the base period
  - Average cost of transfer calculated separately for transfers from ED and transfers from inpatient in the base year
- Sending hospital adjustments
  - Annual adjustments to budgets
  - Adjustments for hospitals with more than 10% increase and at least 10 additional cases
  - If statewide transfers increase by more than 5% ($5 million payment to AMCs), quarterly adjustments and lowering the threshold to 5%.

Measurement and Data Validation

- Case level data has been sent to 22 sending hospitals and 2 AMCs
  - Expanding the window from same day to next day increased the false positives
    - 2% disagreement from sending hospitals (1% if we exclude Sinai Hospital which has 23%)
    - UMMC sent 30% additional cases (1,387), without any exclusions
    - JHH did not send case level results
  - Algorithm is verified, remaining issues with missing CRISP-IDs and hospital records of transfers

Market Share

- 10/1 meeting focused on guiding principles
- Staff shared current service line descriptions
- Case level data for FY2013 and FY2014 made available for modeling
- 10/29 meeting finalize guiding principles

Performance Work Group

- 10/19 meeting discussed QBR FY2017 Changes
- MHAC and readmissions will be the focus for next couple of months

Transfer Cases Payment Adjustment under Global Revenue Models

Health Services Cost Review Commission

4160 Patterson Avenue Baltimore, MD 21215

(410) 764-2605

October 15, 2014

This document contains final report from the Payment Models Work Group. No formal action is required by the Commission.

Introduction

As academic medical centers (AMCs) providing quaternary services, Johns Hopkins Hospital and University of Maryland Medical Center play a distinct role in the health care system by handling a large proportion of highly acute cases, accepting regional referrals, and serving as centers for clinical and technological innovation in the State. For global models to be successful in Maryland, different regulatory treatment must be given to specific clinical service lines at these AMCs that will allow them to function effectively within this new payment structure. Under global models, hospitals are incentivized to lower expenses and volume by taking measures to reduce avoidable utilization and promote care management and quality improvement. This may result in community hospitals transferring complex cases to AMCs in order to get patients the advanced care they need and reduce the high costs associated with those patients. Patients transferred to AMCs are often critically ill patients or patients with highly specialized care not available at the transferring hospitals whose access to care should be ensured. Utilizing AMCs as regional referral centers may improve outcomes for critically ill patients and thus be beneficial to the entire Maryland health system. AMCs must have the capacity to take on a possible influx of complex cases without facing financial penalty under a global model. Inter-hospital transfers is one of those areas of special concern that must be addressed to ensure that resources are readily available to care for complex cases.

Global budgets change financial incentives. Hospitals have reduced incentives to keep highly complex cases that are beyond their capabilities in order to garner revenue. There is also a risk that hospitals could avoid complex cases altogether. HSCRC has included a number of requirements in global budget agreements to monitor for such outcomes including:

- Review of changes in severity levels or case mix of patients treated, with possible revenue reductions for declines;
- Review of volume declines beyond a specified level; and
- Potential revenue adjustments for shifts of services between hospitals (referred to as market share adjustment).

While each of these requirements can detect changing patterns in transfers, the relatively small numbers of complex cases makes transfers a special category of focus. HSCRC wants to ensure that financial policies are in place early in the implementation of global budgets to be responsive to potential changing patterns, aiding in the transfer of patients based on their clinical needs, while ensuring that the receiving entities have the capacity to take on the possible influx of complex cases without facing financial penalty under a global model.

Objectives/Guiding Principles

The HSCRC staff have collected data to aid in the development of a transfer policy. The following are some basic principles to guide the development and implementation of the Commission's transfer policy.

- The primary consideration is for the most appropriate treatment and well-being of the patient being transferred. Transfers should occur in order to serve the best interest of the patient.
- Transfer payment adjustments to the GBR revenues should use corridors to avoid minor adjustments to the GBR revenues.
- The current level and pattern of transfers should be used as the baseline, with subsequent revenue adjustments based on changes in transfer levels from the current level above determined thresholds.
- The Commission should regularly monitor hospitals for changes in transfer patterns for both financial and quality implications.
- The charge for increased transfers should be at a fixed predetermined level. The level should be low enough so that it does not pose a barrier to transfers yet high enough to provide for average incremental resource needs of complex patients transferred.
- Significant changes in the case mix of transfers can be addressed in the review of AMC budgets.
- Unique circumstances such as changing clinical protocols, ambulance patterns, or other changing circumstances can be evaluated on a hospital-specific basis.
- Transfers are a special subcategory of market share. HSCRC will need to take any adjustments made for transfers into account when it makes a market share adjustment.

Data Collection

HSCRC staff proposes to define transfers as same or next day admissions, meaning the discharge date of the initial admission or emergency "admission" will be the same day or the next day as the admission date of the second admission to the academic medical center. The subgroup recommended to expand the definition from same day to next day to include transfers that are admitted after midnight based on the validation results of same day transfers.

HSCRC staff has collected data to aid in the evaluation of transfer cases. Initially, staff focused on the transfer in/transfer out recorded in the case mix data, representing inpatient to inpatient transfers. However, this data has not been used for reimbursement in Maryland and did not prove to be accurate.

- There was confusion regarding whether a patient was being transferred from the emergency room or from an inpatient setting. Given the increasing numbers of observation cases, this confusion is not surprising.
- Referrals were recorded as transfers in the data. There were sometimes multiple day gaps between the transfer out and the transfer in.
- The recording of transfers out and transfers in did not match.

In order to overcome these problems, HSCRC staff has used the master patient index provided from CRISP to track patient flow from one hospital to another. In doing so, patients were tracked with direct transfers from emergency room settings as well as inpatient settings. HSCRC staff will request that selected hospitals review this data to ensure that transfers are being properly identified.

DATA VALIDATION RESULTS INCOMPLETE DRAFT

The table below provides reconciliation results based on data provided to HSCRC as of 10/01/2014 validating same day or next day transfers. In general, the information received from referring hospitals validate the measurement counts (Table 1). On the other hand, AMCs indicated that they have found additional transfer cases that were not included in the HSCRC transfer case list (Table 2). Some of these additional transfer cases send by the University Medical Center do not have CRISP ID (3% of transfer cases identified by HSCRC), which will be further analyzed with CRISP. HSCRC will continue to validate the counts hospital by hospital using case level information from both sending and receiving hospital.

Table 1: Validation Results from Referring Hospitals													
ID	Sending Hospital Name	Total Number of Included Cases	Total Number of Cases Disagreed	Percent Disagree	Total Number of Additional Transfers Sent	Total Number of Additional Transfers met the Inclusion Criteria	Percent Additional	Total Number of Additional Transfers Send - Inpatient	CRISP ID NOT FOUND-Inpatient	Additional Transfers that met the Inclusion Criteria from Inpatient	Total Number of Additional Transfers Send - Outpatient	CRISP ID NOT FOUND-Outpatient	Additional Transfers that met the Inclusion Criteria from Outpatient
210012	SINAI	237	55	23%	0	0	0%	0					
210033	CARROLL COUNTY	511	23	5%	0	0	0%	0					
210005	FREDERICK MEMORIAL	398	15	4%	0	0	0%	0					
210051	DOCTORS COMMUNITY	153	4	3%	0	0	0%	0					
210035	CHARLES REGIONAL	38	0	0%	1186	0	0%	13		0	1173	0	0
210043	BALTIMORE WASHINGTON MEDICAL CENTER	127	0	0%	776	0	0%	37	3	0	725	11	0
210049	UPPER CHESAPEAKE HEALTH	137	0	0%	659	0	0%	90		0	569	0	0
210006	HARFORD	44	0	0%	389	0	0%	37	0	0	352	0	0
210030	CHESTERTOWN	28	0	0%	252	2	0%	5		0	247	0	2
210010	DORCHESTER	20	0	0%	247	1	0%	5		0	242	0	1
210037	EASTON	82	0	0%	239	1	0%	26	1	0	213	1	1
210063	UM ST. JOSEPH	50	0	0%	111	0	0%	10	2	0	99	1	0
210038	UMMC MIDTOWN	42	0	0%	78	0	0%	19		0	59	0	0
210008	MERCY	283											
210015	FRANKLIN SQUARE	419											
210018	MONTGOMERY GENERAL	59											
210024	UNION MEMORIAL	215											
210028	ST. MARY	79											
210034	HARBOR	299											
210044	G.B.M.C.	224											
210056	GOOD SAMARITAN HOSPITAL	375											
210058	REHAB & ORTHO	10											
210062	SOUTHERN MARYLAND	95											
210088	QUEEN ANNE'S EMERGENCY CENTER	69											
218992	UNIVERSITY OF MD SHOCK TRAUMA												
Total		**3,994**	**97**	**2%**	**3937**	**4**	**0%**	**242**	**6**	**0**	**3679**	**13**	**4**

Table 2: Validation Results from Academic Medical Centers		
Receving Hospital Name	University of Maryland and MIEMS	Johns Hopkins University
Total Number of Included Cases	4,569	3,102
Total Number of Cases Disagreed	0	
Percent Disagree	0%	
Additional Cases Send	1,387	
Missing EID	126	
Previous Visit more than 1 day	1,222	
Same System	13	
Not From ED	2	
Total Number of Additional Transfers	0	
Percent Additional	0%	

Transfer Case Exclusions

Certain types of cases have been excluded from the analysis of transfers. Each exclusion and the rationale are discussed below:

- Categorical cases were excluded, because these cases are already being handled under a different global budget review mechanism. The definition of categorical cases is shown in Appendix A.
- Non-Maryland resident transfer cases have been excluded. This may require additional evaluation for hospitals located near the State's borders.
- MDC 5 (cardiology and cardiac surgery) has been excluded. There are alternative competitors for this care, and the HSCRC staff have focused on those categories where the special resources of an AMC resulted in the transfer.
- Psychiatric transfers (based on the receiving institution's recorded APR-DRG of 740,750-760) have been excluded as this is a category where there are a number of institutions providing the service.
- Rehab cases have been excluded (APR_DRG 860, 980-989) based on the planned nature of these transfers.

In addition, transfers within the same hospital or within the same hospital system were excluded from the analysis. Transfers within the same hospital are under the same global budget. Transfers within a hospital system may reflect resource planning approaches and specialization. While global budgets may be adjusted for these transfers, it should occur under a different process.

Transfer Monitoring Categories

To monitor out of state transfers, particularly for border hospitals, and to evaluate the possibility of unintended consequences of the transfer policy, the following additional categories will closely be monitored:

1. Transfers that are excluded from payment adjustments
2. Transfers to out of state providers
3. Levels of ED Diversion
4. Casemix intensity of transfer cases
5. Length of stay of transfer cases in sending and receiving hospitals

Transfer Payment Measures

HSCRC staff is proposing the following measurement for the payment adjustments:

AMC GBR Transfer Adjustments

On a quarterly basis, AMC GBR budgets are adjusted by the increase or decrease in transfer cases net of population adjustment weighted by the average adjusted cost. The average adjusted cost is calculated as the base year average charge *Price update*Variable Cost Factor. The adjustments are done separately for patient transferred from inpatient setting and from Emergency Departments based on the recommendations from the sub-workgroup. Table 1 below illustrates the calculation.

Table 3: Example calculation of AMC Adjustments			
Price Update (1/2FY14Update+1/2FY2015Update)	A		1.68%
VCF	B		50%
Transfers From ED			
Average Charge of Transfer Cases in CY2013	C		$24,159
Average Transfer Case Adjustment	D=	C*(1+A)*B	$12,283
Number of Transfers in the Base Period	E		4,958
Number of Transfers in the Current Period	F		
Total Adjustment	G=	D*(F-E)	
Transfers From Inpatient			
Average Charge of Transfer Cases in CY2013	H		$46,497
Average Transfer Case Adjustment	I=	H*(1+A)*B	$23,639
Number of Transfers in the Base Period	J		2,713
Number of Transfers in the Current Period	K		
Total Adjustment	L=	I*(K-J)	
Total Adjustment	M=	G+L	
Population Adjustment	N		0.70%
Total Transfer Adjustment	O=	M*(1-N)	

Hospital GBR Transfer Adjustments

Hospital's transfer cases will be monitored on a quarterly basis and the GBR revenues will be reduced on an annual basis by the increase in transfer cases weighted by the average adjusted cost. The average adjusted cost for these adjustments will be the same amount for all hospitals and determined according to the formula stated in AMC adjustments. If cumulative payment adjustments to the AMCs exceed 5% of the base year transfer charges, HSCRC staff may adjust the transferring hospital GBR budgets during the course of the fiscal year. Increases in transfers will be netted against decreases in transfers except to the extent that the increase in a particular hospital is above a 10% threshold and there are at least 10 additional transfers. For hospitals with increases above a 10% threshold, those cases above the threshold will be charged to the budget of the GBR hospital, thereby reducing the GBR revenue for the preceding year for that hospital. If the net amount of transfers for the entire State does not exceed an increase of 5% of the base transfers, then no reductions will be made for transfers below a 10% threshold. If the net transfer amount exceeds an increase of 5%, then the excess over 5% will be deducted on a per case basis for those hospitals with increases in transfer cases between 5% and 10%. Table 2 below illustrates the sample calculation.

The trends in transfers will be monitored using monthly case-mix data submissions using CRISP master patient index. The start date of the adjustments for FY 2016 will be based on the progress on data validation.

Table 4: GBR Revenue Transfer Adjustment													
Hospital Name	Annualized Transfer Cases based on CY2013 Jan-May -CY2014 Jan-May						Total Transfer Cost			GBR Revenue Transfer Adjustment			
	2013			2014									
	From ED	From IP	Total	From ED	From IP	Total	2013	2014	% Cost Growth	$ Growth	10 % Threshold $	Additional Transfer Cases	Threshold Adjustment
	A	B	C=A+B	D	E	F=D+E	G=(A*EDCOST) +(B*INP.COST)	H=(D*EDCOST) +(E*INP.COST)	G=H/G-1	I=H-G	J=G*10%	K=F-C	L=IF K>=10; I-J
GARRETT COUNTY	7	0	7	2	7	10	$173,948	$392,761	125.8%	$218,813	$17,395	2	$ -
ST. MARY	46	17	62	82	34	115	$1,882,819	$3,533,708	87.7%	$1,650,889	$188,282	53	-$1,462,607
BALTIMORE WASHINGTON MEDICAL CENTER	110	19	130	106	65	170	$3,559,943	$5,564,241	56.3%	$2,004,299	$355,994	41	-$ 1,648,304
CHARLES REGIONAL	31	10	41	31	19	50	$1,200,145	$1,646,517	37.2%	$446,371	$120,015	10	-$326,357
FT. WASHINGTON	7	10	17	7	14	22	$620,319	$843,505	36.0%	$223,186	$62,032	5	$ -
JOHNS HOPKINS	34	7	41	41	12	53	$1,146,535	$1,543,668	34.6%	$397,133	$114,654	12	-$282,480
HARFORD	31	7	38	41	10	50	$1,088,552	$1,432,076	31.6%	$343,523	$108,855	12	-$ 234,668
CALVERT	89	58	146	144	60	204	$4,823,584	$6,268,777	30.0%	$1,445,193	$482,358	58	-$962,834
UNIVERSITY OF MARYLAND	48	36	84	58	43	101	$2,833,545	$3,400,254	20.0%	$566,709	$283,354	17	-$283,354
UPPER CHESAPEAKE HEALTH	89	29	118	118	26	144	$3,484,470	$4,068,669	16.8%	$584,198	$348,447	26	-$235,751
SOUTHERN MARYLAND	31	29	60	48	26	74	$2,092,888	$2,387,173	14.1%	$294,285	$209,289	14	-$84,997
NORTHWEST	132	77	209	168	72	240	$6,760,014	$7,406,568	9.6%	$646,553	$676,001	31	$ -
MERITUS	170	118	288	235	103	338	$9,584,814	$10,480,787	9.3%	$895,973	$958,481	50	$ -
WESTERN MARYLAND HEALTH SYSTEM	60	46	106	58	50	108	$3,569,829	$3,735,032	4.6%	$165,203	$356,983	2	$ -
CARROLL COUNTY	386	96	482	355	118	473	$13,798,913	$14,049,475	1.8%	$250,562	$1,379,891	-10	$ -
EASTON	89	14	103	67	26	94	$2,814,913	$2,851,034	1.3%	$36,121	$281,491	-10	$ -

Table 4: GBR Revenue Transfer Adjustment

Hospital Name	Annualized Transfer Cases based on CY2013 Jan-May -CY2014 Jan-May						Total Transfer Cost			GBR Revenue Transfer Adjustment			
	2013			2014									
	From ED	From IP	Total	From ED	From IP	Total	2013	2014	% Cost Growth	$ Growth	10 % Threshold $	Additional Transfer Cases	Threshold Adjustment
HARBOR	233	77	310	209	91	300	$9,195,284	$9,285,015	1.0%	$89,731	$919,528	-10	$ -
CHESTERTOWN	38	5	43	43	2	46	$1,150,907	$1,155,280	0.4%	$4,372	$115,091	2	$ -
ST. AGNES	283	156	439	343	120	463	$14,095,482	$13,871,155	-1.6%	-$224,327	$1,409,548	24	$ -
UM ST. JOSEPH	31	19	50	29	19	48	$1,646,517	$1,588,534	-3.5%	-$57,983	$164,652	-2	$ -
QUEEN ANNES	67	0	67	65	0	65	$1,623,513	$1,565,530	-3.6%	-$57,983	$162,351	-2	$ -
UNION HOSPITAL OF CECIL COUNT	48	41	89	38	43	82	$3,056,730	$2,936,393	-3.9%	-$120,338	$305,673	-7	$ -
WASHINGTON ADVENTIST	46	43	89	26	50	77	$3,110,341	$2,981,258	-4.2%	-$129,082	$311,034	-12	$ -
FREDERICK MEMORIAL	190	185	374	204	161	365	$13,173,274	$12,405,241	-5.8%	-$768,033	$1,317,327	-10	$ -
HOWARD COUNTY	139	70	209	161	48	209	$6,599,183	$6,116,691	-7.3%	-$482,492	$659,918	0	$ -
SHADY GROVE	84	79	163	53	86	139	$5,711,955	$5,292,959	-7.3%	-$418,995	$571,195	-24	$ -
MERCY	192	70	262	163	72	235	$7,874,801	$7,290,602	-7.4%	-$584,198	$787,480	-26	$ -
G.B.M.C.	142	79	221	91	94	185	$7,103,537	$6,555,460	-7.7%	-$548,078	$710,354	-36	$ -
ANNE ARUNDEL	235	185	420	235	161	396	$14,274,944	$13,159,015	-7.8%	-$1,115,928	$1,427,494	-24	$ -
FRANKLIN SQUARE	288	151	439	259	139	398	$13,988,261	$12,734,506	-9.0%	-$1,253,755	$1,398,826	-41	$ -
PRINCE GEORGE	36	58	94	46	46	91	$3,547,967	$3,221,933	-9.2%	-$326,034	$354,797	-2	$ -
LAUREL REGIONAL	108	50	158	79	55	134	$4,952,667	$4,480,061	-9.5%	-$472,606	$495,267	-24	$ -
SINAI	151	101	252	106	103	209	$8,339,803	$7,349,727	-11.9%	-$990,077	$833,980	-43	$ -
GOOD SAMARITAN	310	62	372	202	79	281	$10,381,170	$8,553,103	-17.6%	-$1,828,068	$1,038,117	-91	$ -
PENINSULA REGIONAL	262	151	413	254	103	358	$13,350,453	$10,944,648	-18.0%	-$2,405,804	$1,335,045	-55	$ -
UNION	180	46	226	94	60	154	$6,468,959	$5,051,143	-21.9%	-	$646,896	-72	$ -

Table 4: GBR Revenue Transfer Adjustment													
Hospital Name	Annualized Transfer Cases based on CY2013 Jan-May -CY2014 Jan-May						Total Transfer Cost			GBR Revenue Transfer Adjustment			
	2013			2014									
	From ED	From IP	Total	From ED	From IP	Total	2013	2014	% Cost Growth	$ Growth	10 % Threshold $	Additional Transfer Cases	Threshold Adjustment
MEMORIAL										$1,417,817			
REHAB & ORTHO	0	10	10	0	7	7	$446,371	$334,778	-25.0%	-$111,593	$44,637	-2	$ -
HOPKINS BAYVIEW MED CTR	22	12	34	14	10	24	$1,079,808	$794,267	-26.4%	-$285,541	$107,981	-10	$ -
DOCTORS COMMUNITY	48	94	142	58	53	110	$5,511,773	$3,846,625	-30.2%	-$1,665,148	$551,177	-31	$ -
BON SECOURS	238	82	319	173	50	223	$9,534,434	$6,518,197	-31.6%	-$3,016,237	$953,443	-96	$ -
SUBURBAN	7	10	17	7	5	12	$620,319	$397,133	-36.0%	-$223,186	$62,032	-5	$ -
MONTGOMERY GENERAL	43	38	82	41	17	58	$2,829,172	$1,766,854	-37.5%	-$1,062,318	$282,917	-24	$ -
UMMC MIDTOWN	31	12	43	24	5	29	$1,311,738	$803,012	-38.8%	-$508,726	$131,174	-14	$ -
HOLY CROSS	43	60	103	14	36	50	$3,833,508	$2,021,788	-47.3%	-$1,811,720	$383,351	-53	$ -
ATLANTIC GENERAL	84	55	139	46	26	72	$4,596,026	$2,329,191	-49.3%	-$2,266,836	$459,603	-67	$ -
DORCHESTER	24	0	24	7	2	10	$579,826	$285,541	-50.8%	-$294,285	$57,983	-14	$ -
MCCREADY	17	0	17	0	0	0	$405,878	$0	-100.0%	-$405,878	$40,588	-17	$ -
BOWIE HEALTH	12	0	12	0	0	0	$289,913	$0	-100.0%	-$289,913	$28,991	-12	$ -
Total	**4,992**	**2,570**	**7,562**	**4,644**	**2,431**	**7,075**	**$233,302,893**	**$214,102,658**	**-8.2%**	**-$19,200,235)**	**$ 23,330,289**	**-487**	**-$5,521,353**

Data Analysis Results

Table 5: Same and Next Day Transfers Exclusions , CY 2013							
	Receiving Hospital				Total	Percent Total	AMC Percent
	UMMS	MIEMSS	JHH	Non-AMC			
Total Same and Next Day Transfers	8,230	2,402	7,446	35,622	53,700	100%	34%
Transfer Exclusions							
1. Same Hospital	633	58	1309	11937	13,937	26%	-
2.Same System	2,853	765	1,583	6,329	11,530	21%	-
3.Non-Resident	194	113	197	829	1,333	2%	-
4. MDC 5	679	31	722	2548	3,980	7%	**36%**
5.Rehab	0	0	8	1963	1,971	4%	**0%**
6.Pysch	575	1	255	3940	4,771	9%	**17%**
7.Categorical Exclusions	161	0	270	122	553	1%	**78%**
Transfers Included in the Analysis	3,135	1,434	3,102	7,954	15,625	**29%**	**49%**

Counts are mutually exclusive in hieratical order as displayed in the table. *Burn cases at Johns Hopkins Bayview Hospital.

Table 6: Same and Next Day Transfers by Source CY 2013									
	Number of Transfers			Average Charge			Total Charge		
	Source		All	Source		All	Source		All
	From ED	From Inpatient		From ED	From Inpatient		From ED	From Inpatient	
Receiving Hospital									
UMMS	1,687	1,448	3,135	$23,037	$42,998	$32,257	$38,863,914	$62,261,525	$101,125,439
MIEMSS	1,165	269	1,434	$30,147	$70,573	$37,730	$35,121,246	$18,984,038	$54,105,284
JHH	2,106	996	3,102	$21,746	$45,081	$29,239	$45,797,245	$44,900,834	$90,698,079
Total	4,958	2,713	7,671	$24,159	$46,497	$ 32,060	$ 119,782,405	$ 126,146,397	$ 245,928,802
Non-AMC	5,684	2,270	7,954	$10,800	$18,383	$12,964	$61,389,173	$41,728,338	$103,117,510

Table 7: AMC Transfers DRGS with 5 or more Cases					
APR DRG Code	APR DRG NAME	Total charges			Average Age
		N	Mean	Sum	
720	Septicemia & disseminated infections	224	$45,466	$10,184,359	51.82
45	CVA & precerebral occlusion w infarct	188	$21,788	$4,096,208	59.32
53	Seizure	179	$16,508	$2,954,986	25.68
21	Craniotomy except for trauma	164	$80,177	$13,149,086	52.46
55	Head trauma w coma >1 hr or hemorrhage	162	$14,945	$2,421,057	55.08
254	Other digestive system diagnoses	158	$10,086	$1,593,621	34.98
141	Asthma	155	$8,440	$1,308,269	6.45
315	Shoulder, upper arm & forearm procedures	132	$19,458	$2,568,419	26.08
58	Other disorders of nervous system	126	$12,667	$1,595,999	47.5
44	Intracranial hemorrhage	125	$24,033	$3,004,159	61.79
347	Other back & neck disorders, fractures & injuries	121	$10,251	$1,240,380	58.57
383	Cellulitis & other bacterial skin infections	118	$9,737	$1,148,932	36.13
710	Infectious & parasitic diseases including HIV w O.R. procedure	113	$98,346	$11,113,045	53.58
4	ECMO or tracheostomy w long term mechanical ventilation w extensive procedure	112	$250,566	$28,063,364	50.21
139	Other pneumonia	111	$11,645	$1,292,587	17.4
313	Knee & lower leg procedures except foot	103	$38,359	$3,951,020	46.91
282	Disorders of pancreas except malignancy	93	$14,945	$1,389,912	47.14
92	Facial bone procedures except major cranial/facial bone procedures	91	$24,366	$2,217,320	33.6
279	Hepatic coma & other major acute liver disorders	90	$21,957	$1,976,125	51.49
308	Hip & femur procedures for trauma except joint replacement	89	$37,747	$3,359,458	57.49
721	Post-operative, post-traumatic, other device infections	89	$17,195	$1,530,318	46.11
221	Major small & large bowel procedures	82	$61,250	$5,022,463	48.37
466	Malfunction, reaction, complic of genitourinary device or proc	81	$21,955	$1,778,353	49.83
420	Diabetes	80	$9,210	$736,768	21.75
284	Disorders of gallbladder & biliary tract	78	$13,134	$1,024,483	52.86
384	Contusion, open wound & other trauma to skin & subcutaneous tissue	77	$7,606	$585,659	36.14
813	Other complications of treatment	77	$14,776	$1,137,728	52.32
351	Other musculoskeletal system & connective tissue diagnoses	69	$9,183	$633,603	39.17
566	Other antepartum diagnoses	66	$9,220	$608,534	26.47
114	Dental & oral diseases & injuries	64	$6,531	$417,964	36.52
247	Intestinal obstruction	64	$11,732	$750,850	45.78
861	Signs, symptoms & other factors influencing health status	64	$10,230	$654,736	31.94
252	Malfunction, reaction & complication of GI device or procedure	62	$16,171	$1,002,623	49.77
5	Tracheostomy w long term mechanical ventilation w/o extensive procedure	59	$143,937	$8,492,270	55.54
82	Eye disorders except major infections	59	$7,097	$418,731	39.39
115	Other ear, nose, mouth,throat & cranial/facial diagnoses	59	$11,429	$674,299	39.08
138	Bronchiolitis & RSV pneumonia	59	$12,051	$710,982	1.51
143	Other respiratory diagnoses except signs, symptoms & minor diagnoses	59	$14,586	$860,564	38.9
249	Non-bacterial gastroenteritis, nausea & vomiting	59	$7,633	$450,370	25.29
342	Fractures & dislocations except femur, pelvis & back	57	$6,690	$381,340	40.6
57	Concussion, closed skull Fx nos,uncomplicated intracranial injury, coma < 1 hr or no coma	56	$6,436	$360,410	27.82
113	Infections of upper respiratory tract	56	$6,442	$360,738	12.93
130	Respiratory system diagnosis w ventilator support 96+ hours	56	$85,660	$4,796,986	43.77
283	Other disorders of the liver	56	$19,481	$1,090,931	45.2

Table 7: AMC Transfers DRGS with 5 or more Cases					
APR	APR DRG NAME	Total charges			Average
711	Post-op, post-trauma, other device infections w O.R. procedure	56	$50,271	$2,815,199	50.64
133	Pulmonary edema & respiratory failure	53	$36,403	$1,929,351	39.53
248	Major gastrointestinal & peritoneal infections	53	$21,358	$1,131,998	46.09
662	Sickle cell anemia crisis	52	$17,048	$886,473	26.38
253	Other & unspecified gastrointestinal hemorrhage	51	$15,299	$780,224	58.37
812	Poisoning of medicinal agents	50	$10,963	$548,165	20.94
22	Ventricular shunt procedures	49	$60,302	$2,954,781	32.04
463	Kidney & urinary tract infections	49	$8,368	$410,027	32.86
54	Migraine & other headaches	47	$8,549	$401,820	36.11
317	Tendon, muscle & other soft tissue procedures	47	$54,234	$2,548,985	43.94
23	Spinal procedures	46	$72,623	$3,340,663	53.72
241	Peptic ulcer & gastritis	46	$15,904	$731,587	50.83
281	Malignancy of hepatobiliary system & pancreas	45	$17,338	$780,225	64.62
137	Major respiratory infections & inflammations	43	$25,515	$1,097,140	47.6
791	O.R. procedure for other complications of treatment	43	$38,957	$1,675,137	51.21
135	Major chest & respiratory trauma	42	$12,870	$540,550	62.14
225	Appendectomy	42	$17,554	$737,250	12
346	Connective tissue disorders	41	$29,912	$1,226,377	39.56
460	Renal failure	41	$25,509	$1,045,864	54.71
912	Musculoskeletal & other procedures for multiple significant trauma	41	$68,099	$2,792,063	48.39
52	Nontraumatic stupor & coma	40	$32,704	$1,308,144	51.33
121	Other respiratory & chest procedures	40	$48,684	$1,947,367	45.08
243	Other esophageal disorders	39	$12,045	$469,737	40.87
280	Alcoholic liver disease	38	$22,794	$866,153	51.97
663	Other anemia & disorders of blood & blood-forming organs	38	$12,435	$472,513	27.03
930	Multiple significant trauma w/o O.R. procedure	38	$13,951	$530,128	51.58
561	Postpartum & post abortion diagnoses w/o procedure	35	$5,050	$176,767	27.8
20	Craniotomy for trauma	34	$53,024	$1,802,808	54.71
48	Peripheral, cranial & autonomic nerve disorders	34	$16,143	$548,849	45.53
251	Abdominal pain	34	$6,471	$220,024	40.71
24	Extracranial vascular procedures	33	$70,349	$2,321,531	50.91
724	Other infectious & parasitic diseases	33	$21,104	$696,434	34.52
41	Nervous system malignancy	32	$18,108	$579,459	58.41
56	Brain contusion/laceration & complicated skull Fx, coma < 1 hr or no coma	32	$8,447	$270,289	40.41
950	Extensive procedure unrelated to principal diagnosis	32	$67,934	$2,173,898	52.13
144	Respiratory signs, symptoms & minor diagnoses	32	$12,675	$405,586	33.78
844	Partial thickness burns w or w/o skin graft	32	$4,475	$143,194	3.44
305	Amputation of lower limb except toes	31	$81,572	$2,528,718	52.74
220	Major stomach, esophageal & duodenal procedures	30	$60,726	$1,821,786	54.43
301	Hip joint replacement	30	$53,705	$1,611,164	69.13
309	Hip & femur procedures for non-trauma except joint replacement	30	$54,462	$1,633,867	41.57
425	Electrolyte disorders except hypovolemia related	30	$15,950	$478,506	46.57
468	Other kidney & urinary tract diagnoses, signs & symptoms	30	$9,622	$288,651	43.1
304	Dorsal & lumbar fusion proc except for curvature of back	29	$101,162	$2,933,691	57.83
364	Other skin, subcutaneous tissue & related procedures	29	$22,526	$653,241	35.45
816	Toxic effects of non-medicinal substances	29	$16,269	$471,792	40.41
98	Other ear, nose, mouth & throat procedures	28	$17,585	$492,385	32.61
321	Cervical spinal fusion & other back/neck proc exc disc excis/decomp	28	$66,079	$1,850,219	63.96

Table 7: AMC Transfers DRGS with 5 or more Cases					
APR	APR DRG NAME	Total charges			Average
344	Osteomyelitis, septic arthritis & other musculoskeletal infections	28	$29,148	$816,150	49.14
660	Major hematologic/immunologic diag exc sickle cell crisis & coagul	28	$46,869	$1,312,322	42.32
951	Moderately extensive procedure unrelated to principal diagnosis	27	$48,283	$1,303,631	43.07
134	Pulmonary embolism	27	$19,082	$515,222	47.52
723	Viral illness	27	$10,060	$271,624	25.19
49	Bacterial & tuberculous infections of nervous system	26	$41,704	$1,084,316	50.19
245	Inflammatory bowel disease	26	$12,479	$324,441	31.46
260	Major pancreas, liver & shunt procedures	26	$69,436	$1,805,325	53.42
263	Laparoscopic cholecystectomy	26	$22,839	$593,823	37.46
424	Other endocrine disorders	25	$18,677	$466,924	50.84
43	Multiple sclerosis & other demyelinating diseases	24	$33,447	$802,721	43.88
136	Respiratory malignancy	24	$31,122	$746,917	63.5
240	Digestive malignancy	24	$18,958	$454,983	60.46
890	HIV w multiple major HIV related conditions	24	$36,710	$881,045	46.96
314	Foot & toe procedures	22	$28,465	$626,222	42.68
385	Other skin, subcutaneous tissue & breast disorders	22	$9,607	$211,360	36.27
722	Fever	22	$10,292	$226,417	38.36
42	Degenerative nervous system disorders exc mult sclerosis	21	$28,885	$606,581	59.71
690	Acute leukemia	21	$62,222	$1,306,669	61.67
631	Neonate birthwt >2499g w other major procedure	21	$79,492	$1,669,341	0
229	Other digestive system & abdominal procedures	20	$43,213	$864,267	48.35
634	Neonate, birthwt >2499g w resp dist synd/oth maj resp cond	20	$56,262	$1,125,245	0
223	Other small & large bowel procedures	19	$34,715	$659,579	30
224	Peritoneal adhesiolysis	19	$30,221	$574,197	34.84
244	Diverticulitis & diverticulosis	19	$15,702	$298,341	69.74
815	Other injury, poisoning & toxic effect diagnoses	19	$22,700	$431,307	22.58
50	Non-bacterial infections of nervous system exc viral meningitis	18	$43,090	$775,618	48.39
73	Eye procedures except orbit	18	$32,272	$580,897	39
422	Hypovolemia & related electrolyte disorders	18	$10,087	$181,562	42.83
560	Vaginal delivery	18	$11,538	$207,687	24.22
661	Coagulation & platelet disorders	18	$28,616	$515,095	28.33
775	Alcohol abuse & dependence	18	$14,512	$261,224	45.72
142	Interstitial lung disease	17	$27,546	$468,284	56.24
228	Inguinal, femoral & umbilical hernia procedures	17	$22,102	$375,731	22
633	Neonate birthwt >2499g w major anomaly	17	$57,848	$983,415	0
911	Extensive abdominal/thoracic procedures for mult significant trauma	17	$103,346	$1,756,888	39.82
40	Spinal disorders & injuries	16	$23,232	$371,716	59.06
340	Fracture of femur	16	$7,455	$119,287	31.19
380	Skin ulcers	15	$16,497	$247,452	46.53
513	Uterine & adnexa procedures for non-malignancy except leiomyoma	15	$18,683	$280,240	38.87
691	Lymphoma, myeloma & non-acute leukemia	15	$37,047	$555,707	59.67
892	HIV w major HIV related condition	15	$23,987	$359,800	41.13
26	Other nervous system & related procedures	14	$45,818	$641,457	38.43
222	Other stomach, esophageal & duodenal procedures	14	$33,000	$461,998	6.93
320	Other musculoskeletal system & connective tissue procedures	14	$58,442	$818,186	54.29
588	Neonate bwt <1500g w major procedure	14	$271,803	$3,805,239	0
47	Transient ischemia	13	$6,221	$80,873	59.31
70	Orbital procedures	13	$16,202	$210,623	41.23

Table 7: AMC Transfers DRGS with 5 or more Cases					
APR	APR DRG NAME	Total charges			Average
120	Major respiratory & chest procedures	13	$100,765	$1,309,951	37.46
343	Musculoskeletal malignancy & pathol fracture d/t muscskel malig	13	$24,126	$313,637	54.38
540	Cesarean delivery	13	$15,784	$205,189	30.46
811	Allergic reactions	13	$6,126	$79,631	35.85
80	Acute major eye infections	12	$16,200	$194,404	45.83
310	Intervertebral disc excision & decompression	12	$50,855	$610,262	44.5
341	Fracture of pelvis or dislocation of hip	12	$10,164	$121,973	56.25
349	Malfunction, reaction, complic of orthopedic device or procedure	12	$17,081	$204,972	58.08
481	Penis procedures	12	$28,635	$343,620	46.92
132	BPD & oth chronic respiratory diseases arising in perinatal period	11	$25,146	$276,604	2.09
242	Major esophageal disorders	11	$21,748	$239,231	46.82
312	Skin graft, except hand, for musculoskeletal & connective tissue diagnoses	11	$98,163	$1,079,798	37.36
316	Hand & wrist procedures	11	$19,274	$212,018	22.73
401	Pituitary & adrenal procedures	11	$62,635	$688,982	57
423	Inborn errors of metabolism	11	$18,126	$199,390	12.82
443	Kidney & urinary tract procedures for nonmalignancy	11	$24,954	$274,498	47.45
446	Urethral & transurethral procedures	11	$29,460	$324,061	53.27
894	HIV w one signif HIV cond or w/o signif related cond	11	$12,188	$134,067	34.09
97	Tonsil & adenoid procedures	10	$23,112	$231,122	23.1
111	Vertigo & other labyrinth disorders	10	$5,989	$59,890	57.3
952	Nonextensive procedure unrelated to principal diagnosis	10	$30,784	$307,843	49
140	Chronic obstructive pulmonary disease	10	$9,392	$93,918	63.9
246	Gastrointestinal vascular insufficiency	10	$18,020	$180,202	52.7
264	Other hepatobiliary, pancreas & abdominal procedures	10	$51,188	$511,883	55.9
421	Malnutrition, failure to thrive & other nutritional disorders	10	$16,720	$167,201	28.4
483	Testes & scrotal procedures	10	$58,375	$583,746	52.9
531	Female reproductive system infections	10	$7,524	$75,242	29.2
640	Neonate birthwt >2499g, normal newborn or neonate w other problem	10	$7,026	$70,264	0
46	Nonspecific CVA & precerebral occlusion w/o infarct	9	$5,827	$52,445	41.11
51	Viral meningitis	9	$12,359	$111,232	17.89
131	Cystic fibrosis - pulmonary disease	9	$36,218	$325,963	21.22
226	Anal procedures	9	$20,263	$182,364	33.56
227	Hernia procedures except inguinal, femoral & umbilical	9	$41,909	$377,184	63.89
681	Other O.R. procedures for lymphatic/hematopoietic/other neoplasms	9	$50,028	$450,249	61.56
773	Opioid abuse & dependence	9	$6,901	$62,109	42.22
110	Ear, nose, mouth, throat, cranial/facial malignancies	8	$17,974	$143,791	52.25
501	Male reproductive system diagnoses except malignancy	8	$21,296	$170,372	42.13
532	Menstrual & other female reproductive system disorders	8	$10,215	$81,721	38.88
544	D&C, aspiration curettage or hysterotomy for obstetric diagnoses	8	$14,835	$118,677	27.5
609	Neonate bwt 1500-2499g w major procedure	8	$183,274	$1,466,190	0
639	Neonate birthwt >2499g w other significant condition	8	$10,114	$80,915	0
694	Lymphatic & other malignancies & neoplasms of uncertain behavior	8	$52,109	$416,875	47.63
630	Neonate birthwt >2499g w major cardiovascular procedure	8	$133,889	$1,071,109	0
262	Cholecystectomy except laparoscopic	7	$45,620	$319,338	72.43
442	Kidney & urinary tract procedures for malignancy	7	$30,527	$213,690	50.14
465	Urinary stones & acquired upper urinary tract obstruction	7	$9,739	$68,173	35.71
774	Cocaine abuse & dependence	7	$12,824	$89,769	46.14

Table 8: Transfers to AMCs by Sending Hospital , CY2013								
Sending Hospital		Receiving Hospital						All
		UMMS		MIEMSS		JHH		
		Source		Source		Source		
		ED	INPT	ED	INPT	ED	INPT	
Provider ID	HOSPITALNAME							
210033	CARROLL COUNTY	114	73	152	5	133	34	511
210011	ST. AGNES	102	75	96	20	109	52	454
210015	FRANKLIN SQUARE	137	75	53	28	88	38	419
210019	PENINSULA REGIONAL	55	63	79	13	140	60	410
210005	FREDERICK MEMORIAL	47	119	57	9	90	79	401
210023	ANNE ARUNDEL	43	66	46	18	131	84	388
210056	GOOD SAMARITAN	137	48	63	14	79	34	375
210001	MERITUS	92	73	59	14	61	24	323
210034	HARBOR	80	63	77	4	55	20	299
210013	BON SECOURS	105	56	74	4	32	25	296
210008	MERCY	104	51	18	8	83	19	283
210012	SINAI	46	44	10	12	80	45	237
210048	HOWARD COUNTY	87	54	73	15	.	.	229
210044	G.B.M.C.	27	26	34	6	67	64	224
210040	NORTHWEST	47	40	28	5	57	41	218
210024	UNION MEMORIAL	57	25	30	7	82	14	215
210039	CALVERT	61	43	16	8	36	15	179
210055	LAUREL REGIONAL	38	40	41	8	24	10	161
210051	DOCTORS COMMUNITY	19	74	17	8	14	21	153
210057	SHADY GROVE	13	35	15	9	34	32	138
210061	ATLANTIC GENERAL	26	47	19	5	31	10	138
210049	UPPER CHESAPEAKE HEALTH	.	.	.	.	108	29	137
210043	BALTIMORE WASHINGTON MEDICAL CENTER	.	.	.	.	101	26	127
210027	WESTERN MARYLAND HEALTH SYSTEM	19	17	12	6	47	26	127
210003	PRINCE GEORGE	31	47	12	9	7	8	114
210004	HOLY CROSS	12	36	7	5	20	20	100
210062	SOUTHERN MARYLAND	19	27	9	8	22	10	95
210032	UNION HOSPITAL OF CECIL COUNT	18	27	7	7	22	6	87
210037	EASTON	.	.	.	.	67	15	82
210016	WASHINGTON ADVENTIST	22	35	6	2	8	8	81
210002	UNIVERSITY OF MARYLAND	.	.	.	.	52	29	81
210028	ST. MARY	24	15	10	3	16	11	79
210088	QUEEN ANNES	23	.	25	.	21	.	69
210018	MONTGOMERY GENERAL	13	14	2	4	18	8	59
210063	UM ST. JOSEPH	.	.	.	.	27	23	50
210009	JOHNS HOPKINS	35	7	6	.	.	.	48
210006	HARFORD	.	.	.	.	30	14	44
210038	UMMC MIDTOWN	.	.	.	.	27	15	42
210035	CHARLES REGIONAL	.	.	.	.	28	10	38
210029	HOPKINS BAYVIEW MED CTR	17	11	2	2	.	.	32
210030	CHESTERTOWN	.	.	.	.	26	2	28
210060	FT. WASHINGTON	3	10	2	2	6	2	25
210010	DORCHESTER	.	.	.	.	18	2	20
210022	SUBURBAN	5	9	2	1	.	.	17
210045	MCCREADY	5	1	2	.	5	.	13
210058	REHAB & ORTHO	.	.	.	.	.	10	10
210333	BOWIE HEALTH	3	.	3	.	3	.	9
210017	GARRETT COUNTY	1	2	1	.	1	1	6
Total		1,687	1,448	1,165	269	2,106	996	7,671

Table 9: CY 2013 and CY 2014 5 Month Trends				
		Calendar Year		% CHANGE
		2013	2014	
		Jan-May	Jan-May	
Number of Cases	Receiving Hospital			
	UMMS	1227	1158	-5.62%
	MIEMSS	615	477	-22.44%
	JHH	1309	1313	0.31%
	Non-AMC	3610	2910	-19.39%
Average Charge	UMMS	$32,346	$37,968	17.38%
	MIEMSS	$37,222	$44,971	20.82%
	JHH	$28,304	$26,032	-8.03%
	Non-AMC	$13,047	$13,036	-0.09%
Total Charge	UMMS	$39,688,623	$43,967,223	10.78%
	MIEMSS	$22,891,474	$21,451,188	-6.29%
	JHH	$37,049,552	$34,179,858	-7.75%
	Non-AMC	$47,099,801	$37,934,418	-19.46%

Based on March-May Preliminary Data 7/31/2014

Table 10: CY 2013 and CY 2014 5-Month Trends by Hospital									
SENDING HOSPITAL NAME	Receiving Hospital								% Total Change
	1_UMMS		2_MIEMSS		3_JHH		Total		
	Jan-May		Jan-May		Jan-May		Jan-May		
	2013	2014	2013	2014	2013	2014	2013	2014	
ST. MARY	10	16	8	6	8	26	26	48	85%
CALVERT	38	38	9	14	14	33	61	85	39%
GARRETT COUNTY	1	2	1	1	1	1	3	4	33%
HARFORD	.	.	.	.	16	21	16	21	31%
CHARLES REGIONAL	.	.	.	.	17	21	17	21	24%
BALTIMORE WASHINGTON MEDICAL CENTER	.	.	.	.	54	71	54	71	31%
JOHNS HOPKINS	15	22	2	.	.	.	17	22	29%
SOUTHERN MARYLAND	12	13	5	4	8	14	25	31	24%
UPPER CHESAPEAKE HEALTH	.	.	.	.	49	60	49	60	22%
MERITUS	65	84	26	26	29	31	120	141	18%
UNIVERSITY OF MARYLAND	.	.	.	.	35	42	35	42	20%
NORTHWEST	29	49	20	16	38	35	87	100	15%
FT. WASHINGTON	4	3	2	4	1	2	7	9	29%
CHESTERTOWN	.	.	.	.	18	19	18	19	6%
ST. AGNES	70	79	44	48	69	66	183	193	5%
WESTERN MARYLAND HEALTH SYSTEM	11	14	7	7	26	24	44	45	2%
BOWIE HEALTH	.	.	3	.	2	.	5	0	0%
HOWARD COUNTY	52	51	35	36	.	.	87	87	0%
FREDERICK MEMORIAL	63	56	28	24	65	72	156	152	-3%
HARBOR	58	61	42	21	29	43	129	125	-3%
CARROLL COUNTY	71	62	65	62	65	73	201	197	-2%
QUEEN ANNES	7	9	8	8	13	10	28	27	-4%
UM ST. JOSEPH	.	.	.	.	21	20	21	20	-5%
PRINCE GEORGE	28	26	7	2	4	10	39	38	-3%
ANNE ARUNDEL	45	43	24	29	106	93	175	165	-6%
UNION HOSPITAL OF CECIL COUNT	22	18	6	2	9	14	37	34	-8%
EASTON	.	.	.	.	43	39	43	39	-9%
FRANKLIN SQUARE	100	88	33	20	50	58	183	166	-9%
MERCY	64	48	9	10	36	40	109	98	-10%
WASHINGTON ADVENTIST	24	22	4	3	9	7	37	32	-14%
PENINSULA REGIONAL	43	36	39	20	90	93	172	149	-13%
SHADY GROVE	23	31	11	7	34	20	68	58	-15%
G.B.M.C.	18	23	18	6	56	48	92	77	-16%
LAUREL REGIONAL	30	31	24	17	12	8	66	56	-15%
SINAI	42	37	8	10	55	40	105	87	-17%
DOCTORS COMMUNITY	31	20	9	11	19	15	59	46	-22%
GOOD SAMARITAN	68	50	36	23	51	44	155	117	-25%
REHAB & ORTHO	.	.	.	.	4	3	4	3	-25%
MONTGOMERY GENERAL	16	7	6	1	12	16	34	24	-29%
HOPKINS BAYVIEW MED CTR	12	9	2	1	.	.	14	10	-29%
SUBURBAN	6	5	1	.	.	.	7	5	-29%
BON SECOURS	69	54	38	16	26	23	133	93	-30%
UNION MEMORIAL	26	26	18	12	50	26	94	64	-32%
UMMC MIDTOWN	.	.	.	.	18	12	18	12	-33%
ATLANTIC GENERAL	29	16	10	7	19	7	58	30	-48%
HOLY CROSS	23	9	6	3	14	9	43	21	-51%
DORCHESTER	.	.	.	.	10	4	10	4	-60%
MCCREADY	2	.	1	.	4	.	7	0	-100%
Total	**1227**	**1158**	**615**	**477**	**1309**	**1313**	**3151**	**2948**	**-6.4%**

Table 11: AMC Transfers by Product Line (HSCRC revised)				
Product Line	Total charges			Average Age
	N	Mean	Sum	
Neurology	1072	$17,608	$18,876,257	47.5
Gastroenterology	987	$14,712	$14,520,854	45.19
General Surgery	715	$49,745	$35,567,517	44.7
Pulmonary	642	$21,934	$14,081,457	25.05
Orthopedic Surgery	562	$43,711	$24,565,366	44.57
Infectious Disease	505	$30,327	$15,315,083	44.05
Neurological Surgery	294	$70,985	$20,869,664	48.47
General Medicine	220	$11,773	$2,590,059	24.65
Orthopedics	218	$9,486	$2,067,951	51.71
Oncology	217	$28,675	$6,222,439	59.43
Nephrology	207	$17,374	$3,596,420	45.46
Ventilator Support	171	$213,776	$36,555,635	52.05
Trauma	140	$40,481	$5,667,279	52.21
ENT Surgery	139	$24,004	$3,336,513	32.09
Hematology	136	$23,429	$3,186,403	30.1
Otolaryngology	125	$8,759	$1,094,928	28.82
Neonatology	125	$97,768	$12,221,014	0
Injuries/complic. of prior care	120	$23,441	$2,812,865	51.93
Dermatology	117	$9,001	$1,053,098	37.16
Other Obstetrics	116	$8,282	$960,716	26.86
Rheumatology	110	$16,909	$1,859,980	39.32
Endocrinology	94	$15,889	$1,493,583	41.11
Diabetes	80	$9,210	$736,768	21.75
Spinal Surgery	74	$70,147	$5,190,882	57.59
Ophthalmology	71	$8,636	$613,135	40.48
Dental	64	$6,531	$417,964	36.52
Urological Surgery	56	$38,176	$2,137,877	47.2
HIV	54	$26,458	$1,428,732	42.35
Thoracic Surgery	53	$61,459	$3,257,317	43.21
Substance Abuse	42	$11,230	$471,669	43.93
Obstetrics/Delivery	34	$14,731	$500,861	27.15
Ophthalmologic Surg	31	$25,533	$791,520	39.94
Gynecological Surg	25	$15,966	$399,162	32.92
Gynecology	18	$8,720	$156,963	33.5
Endocrinology Surgery	17	$62,699	$1,065,875	58.41
Urology	15	$15,903	$238,545	39.13
Ungroupable	5	$1,290	$6,452	31.6

Table 12: AMC Transfer Trends by Product Line (HSCRC revised) Jan-May 5-Month Trends									
Product Line	**Number of Transfers**			**Average Charge**			**Total Charge**		
	2013	**2014**	**% Change**	**2013**	**2014**	**% Change**	**2013**	**2014**	**% Change**
Dental	34	7	**-79%**	$7,220	$15,847	119%	$245,487	$110,929	-55%
Dermatology	56	27	**-52%**	$7,421	$11,195	51%	$415,592	$302,255	-27%
HIV	31	17	**-45%**	$26,758	$36,131	35%	$829,504	$614,226	-26%
Ophthalmologic Surg	16	9	**-44%**	$30,644	$27,458	-10%	$490,297	$247,123	-50%
Other Obstetrics	61	35	**-43%**	$10,169	$10,586	4%	$620,316	$370,523	-40%
Gynecology	11	7	**-36%**	$5,646	$14,898	164%	$62,103	$104,287	68%
Orthopedics	91	58	**-36%**	$9,029	$14,570	61%	$821,605	$845,063	3%
Ophthalmology	36	23	**-36%**	$8,465	$8,340	-1%	$304,735	$191,822	-37%
Gynecological Surg	9	6	**-33%**	$19,863	$27,807	40%	$178,771	$166,841	-7%
Injuries/complic. of prior care	58	40	**-31%**	$21,047	$27,211	29%	$1,220,741	$1,088,440	-11%
Otolaryngology	61	44	**-28%**	$8,353	$9,777	17%	$509,539	$430,193	-16%
Neonatology	57	42	**-26%**	$101,238	$56,881	-44%	$5,770,588	$2,388,992	-59%
Rheumatology	33	25	**-24%**	$15,307	$18,739	22%	$505,145	$468,466	-7%
Diabetes	42	32	**-24%**	$7,404	$8,724	18%	$310,958	$279,170	-10%
Obstetrics/Delivery	13	10	**-23%**	$12,435	$31,927	157%	$161,658	$319,269	97%
Endocrinology Surgery	5	4	**-20%**	$57,325	$20,283	-65%	$286,627	$81,130	-72%
ENT Surgery	54	50	**-7%**	$26,276	$25,990	-1%	$1,418,886	$1,299,477	-8%
Gastroenterology	404	375	**-7%**	$13,548	$16,233	20%	$5,473,475	$6,087,480	11%
Neurology	445	417	**-6%**	$17,657	$17,083	-3%	$7,857,237	$7,123,448	-9%
Ventilator Support	77	73	**-5%**	$213,169	$235,058	10%	$16,413,986	$17,159,210	5%
Infectious Disease	184	179	**-3%**	$30,097	$28,437	-6%	$5,537,840	$5,090,155	-8%
Neurological Surgery	122	119	**-2%**	$69,015	$64,684	-6%	$8,419,847	$7,697,404	-9%
Orthopedic Surgery	210	208	**-1%**	$46,538	$47,029	1%	$9,773,054	$9,782,039	0%
Endocrinology	36	36	**0%**	$11,852	$15,929	34%	$426,655	$573,431	34%
Pulmonary	258	264	**2%**	$20,102	$24,084	20%	$5,186,293	$6,358,043	23%
Urological Surgery	26	27	**4%**	$35,791	$44,683	25%	$930,562	$1,206,438	30%
Nephrology	90	95	**6%**	$16,850	$24,839	47%	$1,516,475	$2,359,710	56%
General Surgery	287	304	**6%**	$46,529	$50,769	9%	$13,353,738	$15,433,866	16%
General Medicine	90	96	**7%**	$10,126	$11,279	11%	$911,366	$1,082,831	19%
Trauma	50	54	**8%**	$50,663	$40,460	-20%	$2,533,135	$2,184,825	-14%
Thoracic Surgery	20	22	**10%**	$54,681	$52,699	-4%	$1,093,613	$1,159,369	6%
Substance Abuse	17	19	**12%**	$10,734	$6,770	-37%	$182,481	$128,629	-30%
Hematology	49	56	**14%**	$14,115	$28,566	102%	$691,619	$1,599,722	131%
Spinal Surgery	27	31	**15%**	$74,129	$64,346	-13%	$2,001,492	$1,994,728	0%
Oncology	86	99	**15%**	$35,636	$29,131	-18%	$3,064,698	$2,883,946	-6%
Urology	6	7	**17%**	$20,567	$9,253	-55%	$123,404	$64,773	-48%
Ungroupable	.	**21**		.	$7,577		.	$159,117	

Appendix- Categorical Cases Definitions

1. Categorical Case Exclusions
    1.1. Solid Organ Transplants APR DRGS = 001, 002, 003, 006 or 440
    (any procedure = 5280, 5282 or 5283 or any procedure = 5280, 5282, 5283, 4100, 4101, 4102, 4103, 4104, 4105, 4106, 4107, 4108 or 3751 Heart Transplantation 4109 or 336 or 3350 , 3351, 3352, 5569, 5561, 5281, 5051, or 5059)
    1.2. Melodysplastic - Any Diagnosis = 2387 for Johns Hopkins Oncology Center
    1.3. JHU Pediatric Burn Cases (Age < 18) - 3rd Degree Burns
    1.4. Johns Hopkins and University Oncology Center
        1.4.1. Transplant Cases (Reserve Flag = 1)
        1.4.2. Research Cases (Reserve Flag = 2)
        1.4.3. Hematological Cases (Reserve Flag = 3)
        1.4.4. Transfer in Cases (Reserve Flag = 4)

Update on the Medical Care Data Base

HSCRC Commission Meeting
October 15, 2014

Ben Steffen
Executive Director
Maryland Health Care Commission

Medical Care Data Base

(All Payer Claims Database)

- Components
  - Privately Insured
  - Medicare controlled by CMS data use agreements – highly restrictive
  - Medicaid – MCO claims lack payment information due to limitations of MMIS II

- Availability schedule as of 2014
  - Privately insured
    - Annual 8-9 months after year ends
    - Data base of privately insured claims created by Maryland Legislature
  - Medicare
    - Annual approximately 10-12 months after year ends
    - MHCC collaborating with HSCRC and others to obtain frequent data feeds. Questions exists about more current data collected quarterly
  - Medicaid
    - DHMH has agreed to provide annual files in MCDB format prepared by Hilltop
    - Annual approximately 9-10 months after year end, release schedule is being worked
    - DHMH can approve release of Medicaid data

Privately Insured Component of MCDB

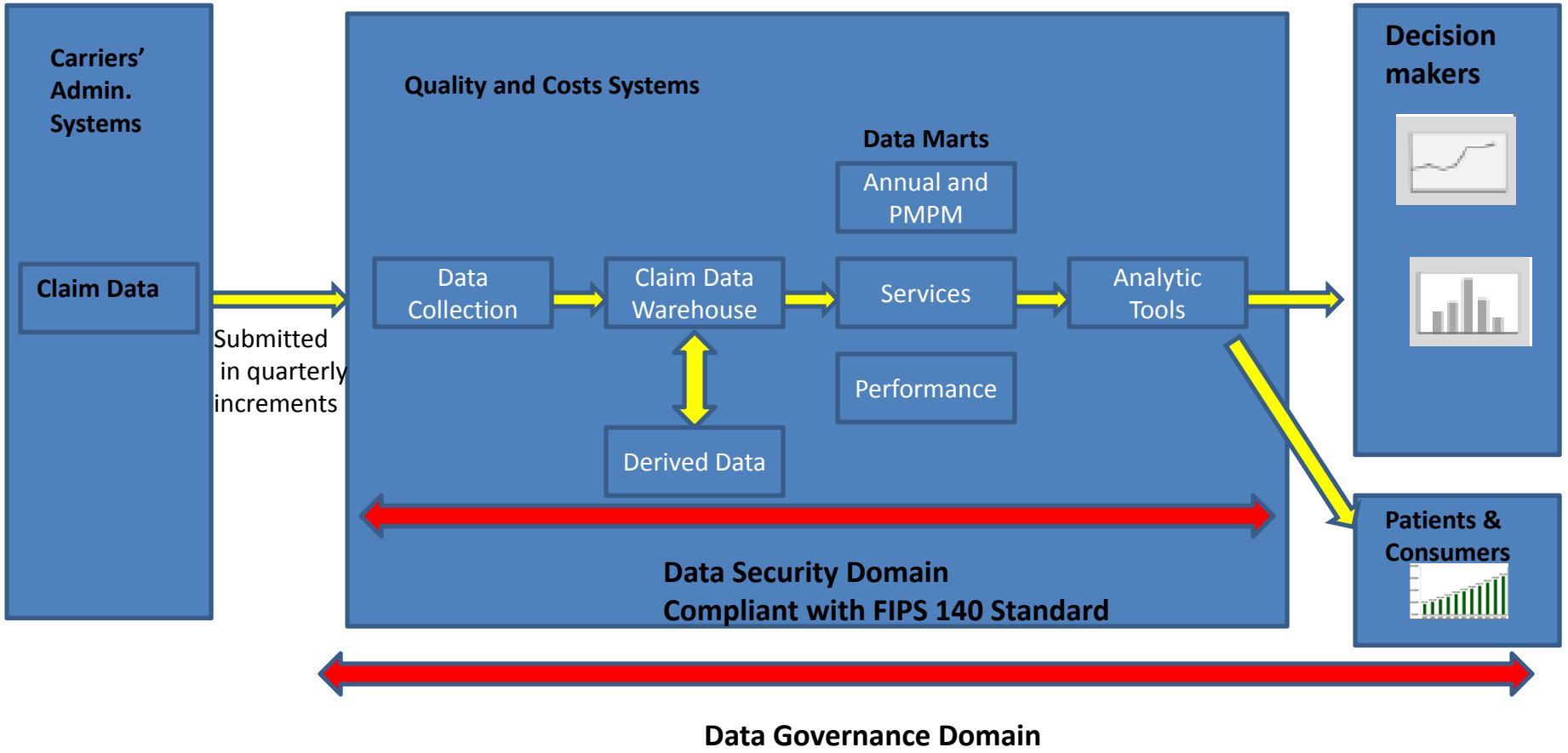
- Data base of privately insured claims created by Maryland Legislature
  - New in 2014: PBMs, TPAs, QHPs must submit; report on non-FFS payments to providers (in development); and submissions become quarterly, based on claim paid date
  - What's included
    - Carriers, PBMs, TPAs licensed in Maryland with ≥ 1,000 covered lives
    - Enrollees residing in Maryland (or covered under Maryland contracts)
    - About half of privately insured are in self-funded employer plans, which typically carve-out Rx and sometimes behavioral health from medical care plan
    - MHCC estimates regulations cover ~ 90% of all privately insured
  - What's not included
    - Maryland Federal employees insured by insurers not licensed in Maryland – GEHA, Treasury, State Department plans
    - Maryland residents insured by out-of-state health plans PA, Delaware, and WV BCBS

MCDB File Details – Patient Information

Eligibility file

- Enrollment/disenrollment dates and plan information
  - Source of coverage: small employer, individual market, etc.
- Encrypted unique patient identifiers (3)
  - Specific to carrier/plan enrollment
  - MHCC's Universally Unique Identifier (UUID) based on SSN
  - CRISP's Master Patient Index from major submitters in 2014
- Patient protections: no names; birth day omitted; location identified only by zip code

How claim data become useful



Why does it take so long?

- Submitter issues
  - Rules regarding claims
    - Private payers allow providers up to 6 months to submit claims
    - Medicaid and Medicare allow similarly long periods
    - Complex claims may require multiple submissions
  - Multiple file specifications from APCD states
- MHCC issues
  - Multiple submitters * multiple files
  - Payer compliance issues require repeated submissions
  - Reconciliation of multiple submitters to create common database
  - Derived data elements
- Medicare and Medicaid have similar challenges and similar turnarounds

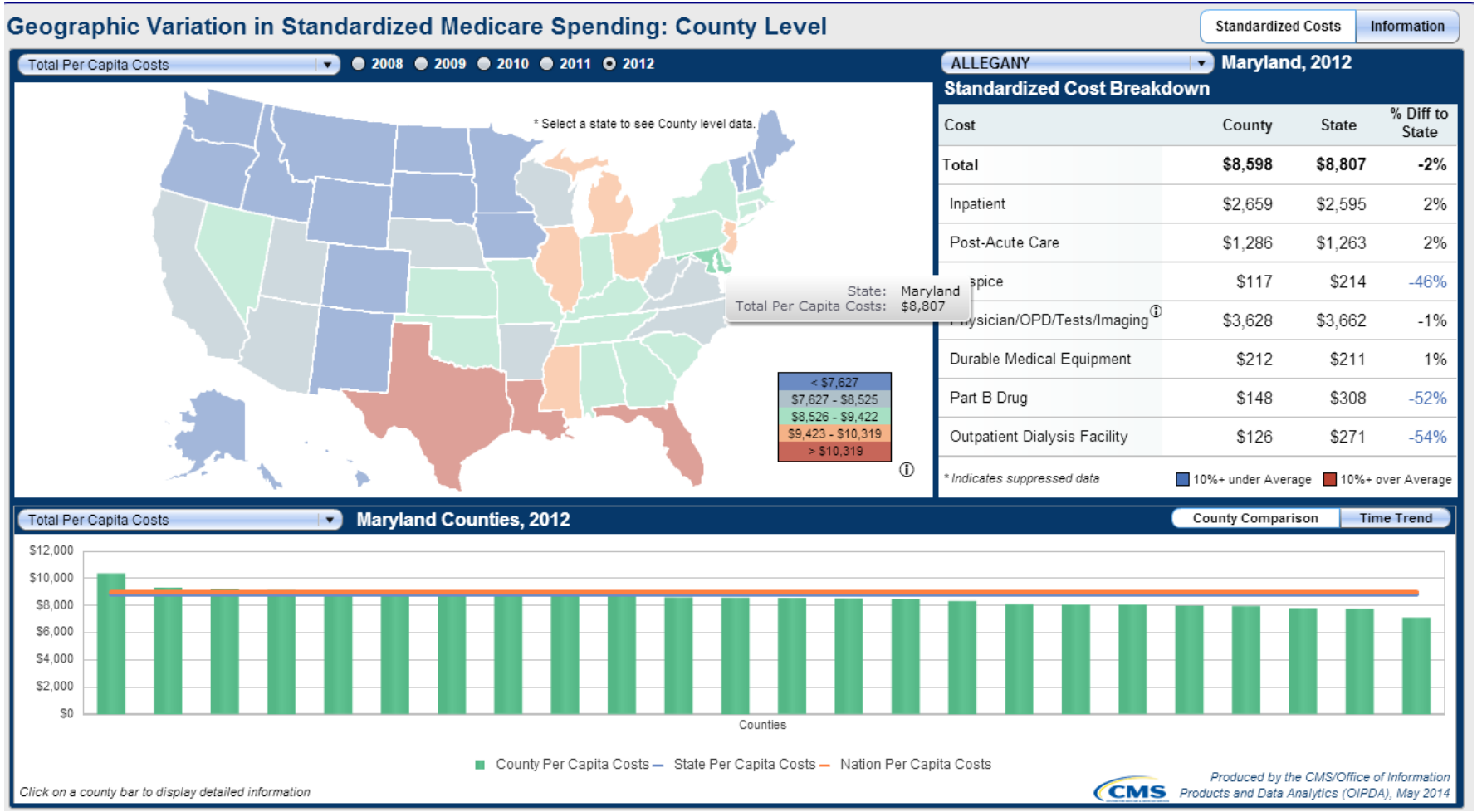
What has MHCC accomplished in 2014?

- Payer education and engagement expanded
- Launched ETL application to expedite data uptake and processing
  - Payer submission and first stage edits automated
  - Application will expand over the next year
  - More frequent submissions may lead to more standardization
- MHCC commits to expedited release schedule
  - Calendar 2013 data available now with derived data elements
  - Calendar 2014 data available by end of May 2015 without derived data elements
  - Calendar 2014 with Q1 2015 available by end of August 2015 without derived data elements
  - Calendar 2014 with derived data elements available by end of September 2015

What are MHCC's plans?

- MHCC staff is supporting HSCRC staff to develop Total Cost of Care definitions. Once standardized, flags and fields will be included in MCDB files.
- Plan to develop new products
  - Data products:
    - Per capita, resident summary file
    - Geographic summary files
  - Web-based, interactive data marts targeted at:
    - Industry
    - Provider
    - Consumer

Expanded use of the MCDB for Monitoring Per Capita Spending: the Medicare Experience



State of Maryland
Department of Health and Mental Hygiene

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Hospital Rate Setting

Sule Calikoglu, Ph.D.
Deputy Director
Research and Methodology

TO: **Commissioners**

FROM: **Legal Department**

DATE: **October 15, 2014**

RE: **Hearing and Meeting Schedule**

November 12, 2014	Time to be determined, 4160 Patterson Avenue HSCRC Conference Room
December 10, 2014	Time to be determined, 4160 Patterson Avenue HSCRC Conference Room

Please note that the Commissioner's packets will be available in the Commission's office at 11:45 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.
http://hscrc.maryland.gov/commission-meetings-2014.cfm

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