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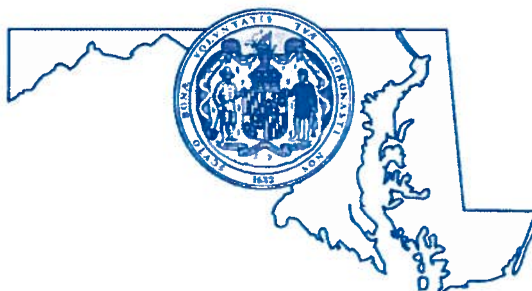

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MEMORANDUM

TO: Interested Parties: Reasonableness of Charges Methodologies

FROM: Robert Murray

DATE: December 22, 2010

RE: ICC/ROC Issues

Each year, the Health Services Cost Review Commission ("Commission") reviews its methodologies. On September 1, 2010, the Commission requested proposals for changes to the Reasonableness of Charges (ROC) and Inter-hospital Cost Comparison (ICC) methodologies. Before to the October 1, 2010 deadline for responses, the Commission received 5 letters suggesting modifications to existing policies. Attachment 1 summarizes those proposed changes. Proposals were received from the following representatives:

1. Maryland Hospital Association ("MHA") on behalf of its members;
2. Johns Hopkins Health System ("JHHS")
3. University of Maryland Medical System ("UMMS")
4. Cohen, Rutherford and Knight on behalf of the G-9 hospitals;
5. CareFirst BlueCross Blue Shield and Kaiser Permanente

Commission staff met to discuss each of these proposals and itemized the issues that could be addressed during this review.

Technical Issues

In its letter, MHA requested clarification on several technical issues. The Commission does not believe that it is necessary to address these issues through an ICC/ROC work group, but, rather

will provide a response in this memorandum. Those issues are as follows:

1. **Review the detailed calculations and data inputs for the outpatient charge-per-visit (CPV) targets, charge-per-case (CPC) targets and comprehensive charge target (CCT) used in the ROC.**

   These issues relate to the calculation of the CCT and do not directly relate to the ICC/ROC methodologies. The Commission previously vetted these calculations with the representative industries, and the CCT for FY 2011 has been issued. If MHA has specific questions, staff is always willing to respond to those individually.

   The HSCRC will convene a CPV Work Group in the winter of 2011 to discuss technical issues related to the CPV. Any CPV-related issues can be addressed in this forum.

2. **Decide whether one-day stay cases are included in the CPC target for the ROC.**

   During the one-day length of stay deliberations that took place in the spring of this year the Commission established several policies related to one-date stays. One of those was to exclude one-day stay cases from the CPC target for ROC purposes.

3. **Adjust on a one-time basis, not a permanent basis, hospital rates for QBR and MHACs.**

   The QBR and MHAC adjustments in FY 2011 were considered one-time adjustments. This is considered to be current Commission policy.

4. **Re-establish transparency processes in which HSCRC staff make available to hospitals and interested parties, two weeks prior to public release, the data inputs and preliminary ROC results.**

   Staff intends to continue to comply with the policy of making data inputs and the preliminary ROC results available to hospitals two weeks before public release. The delay in resident and intern submissions this year made it difficult to comply with this policy. A recently approved deadline for resident and intern submissions should alleviate this problem in future years.

<u>Capital Policy and GME incentive for Primary Care Residencies</u>

In light of proposed changes to the payment system, including the expansion of fixed cost payment arrangements at Maryland hospitals, staff believes it is necessary to revisit the Commission's overall capital policy. As payment incentives are changed to encourage volume reduction, the Commission staff sees a need to revisit how capital costs are considered under its methodologies, and what the appropriate ratios of fixed/variable costs are for volume change.

Additionally, to the extent that bundled payment strategies (such as through Admission-Readmission Revenue and Total Patient Revenue arrangements) encourage more coordination and interaction with primary care physicians, staff believes it is appropriate to consider altering the GME methodology to encourage hospitals to implement or expand primary care residencies. The Commission's existing uncompensated care policy includes a provision to reward hospitals that have higher proportions of charity care compared to bad debt. A similar method could be used to provide incentives to hospitals with primary care residencies.

The Commission will establish a separate work group to address these capital, variable cost, and GME issues. Staff intends to convene meetings of this work group beginning in January 2011.

Medium and Long Term Issues

Most of the proposals expressed a desire to limit the scope of methodological changes this year - given the breadth of other policy changes that are being implemented and considered in the near future. Nonetheless, staff believes that, at a minimum, the following issues should be considered over a longer period of time:

1. National Peer Group;
2. ICC/ROC Analysis once every Three Years; and
3. Reporting of Physician Subsidies.

The Commission thanks those representatives who proposed changes. We look forward to working with those representatives, affiliated industries, and other stakeholders to continue to refine the Commission's ICC/ROC methodologies.

Summary of ICC/ROC Issues for 2010/2011

I. MHA

1. Technical Issues Only - Maintain the ROC/ICC analyses essentially unchanged this year. The only exceptions would be addressing "technical issues" to clarify and add transparency to the methodology:

    a. Review the detailed calculations and data inputs for the outpatient charge-per-visit (CPV) targets, charge-per-case (CPC) targets, and comprehensive charge target (CCT) used in the ROC.

    b. Decide whether one-day stay cases are included in the CPC target for the ROC.

    c. Adjust on a one-time basis, not a permanent basis, hospital rates for QBR and MHACs.

    d. Re-establish transparency processes in which HSCRC staff make available to hospitals and interested parties, two weeks prior to public release, the data inputs and preliminary ROC results.

2. National peer group and IME – Not in this forum but believe the IME adjustment must be revised when the academic medical center peer group is reconfigured.

3. Physician Subsidies – Want to revisit considering an accounting for the cost to provide physician coverage; however, the letter states that the cost of physician subsidies requires a broader policy perspective beyond the scope of ROC.

II. JHHS and UMMS

1. Agree with MHA recommendations – "We recommend that no changes be evaluated and considered this year except the technical adjustments, as suggested by the MHA."

2. Commented that:

    a. Scaling - the 15% scaling methodology in the FY 2011 update factor methodology is too extreme.

    b. National Peer Group – If being addressed, there must be an extensive review of outliers. Recommend returning to the statistical definition of outliers such as mean charge plus 1.5 standard deviations.

    c. Listed areas where ROC does not fully account for the unique costs of AMCs:
        i. JHHS:
            1. Tertiary and Specialty Services Costs;

2. Specialty Psychiatry;
3. Location and Facility;
4. Transfer-In Cases;
5. Unmeasured Severity of Illness; and
6. Research Intensive Hospitals Services

ii. UMMS:

1. Kernan Hospital – Remove from Non-Urban Teaching Group and compare on statewide average adjusted charge per EIPC; and
2. Chester River Hospital Center – exclude from any negative scaling that might apply in FY 2012 and future years.

III. G9

1. Agree with MHA recommendations.

2. Partial Rate Applications for Capital (PRACs)- Representatives of G-9 stated that, during the last round of deliberation, the HSCRC staff committed to addressing this issue, and in particular, the inconsistency between the current regulations governing PRACs and the newly-adopted capital policy that was proposed by the payers. This letter states that, in combination, the application for capital is too rigorous and makes it nearly impossible for hospitals to receive rate adjustments for new capital projects.

IV. CareFirst and Kaiser

1. Timing of ICC/ROC Analysis – ICC/ROC reviewed every 3 years.

2. National Peer Group – Update on process for evaluating feasibility of using a National Peer Group.

3. Kidney Transplants – Bring Kidney Transplants into CPC and ROC.

4. Scaling and Spend downs – support absence of spend downs if:

   a. ROC scaling is significant - no less that this year; and
   b. There is no easing in full rate review standard, with the possible exception of removal of profit strip for capital partials.

5. Outlier Payments – Consider Dr. Cook's proposal from last year.

6. Separate inpatient and outpatient OR rates – Have separate per minute rates for inpatient and outpatient OR minutes.

7. Definition of high cost hospitals – 3% above the mean of the peer group disadvantages non-teaching hospitals. The letter suggested developing the definition statistically

(certain number of standard deviations above peer group mean) or based on equitability (such as top 4 non-teaching and top 2 teaching hospitals).

8. Review Clinic Volumes – clinic volumes, especially for multi-person behavioral health clinics, may be too high and request that they be reviewed.

9. Non-comparable services – It may be that there are a limited number of services that differ substantially at a particular hospital from its comparison group. The letter states that there should be objective methods of identifying and evaluating the cost of those services.

10. Primary Care Incentive in DME/IME – As indicated last year, GME should include an incentive for hospitals to implement or expand primary care residencies.