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POST MEETING AND APPROVED DOCUMENTS FROM THE:

468th MEETING OF THE HEALTH SERVICES COST REVIEW COMMISSION

PUBLIC SESSION

June 9, 2010

1. **Docket Status - Cases Open**
   2068A - University of Maryland Medical Center
   2069A - University of Maryland Medical Center
   2070A - University of Maryland Medical Center
   2072R - Suburban Hospital

2. **Final recommendation on Revisions to the Reasonableness of Charges (ROC) Methodology**

3. **Final Recommendation on Reallocation of Case Mix to Hospitals that were early Adopters of Observation Units (From One Day Length of Stay Recommendations)**

4. **Community Benefit Report Update**

5. **Legal Report**

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION	*	**COMMISSION**	
UNIVERSITY OF MARYLAND	*	**DOCKET:**	**2010**
MEDICAL CENTER	*	**FOLIO:**	**1878**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2068A**

Staff Recommendation

June 9, 2010

I. INTRODUCTION

University of Maryland Medical Center (“UMMC” or ‘the Hospital”) filed an application with the HSCRC on April 28, 2010 for an alternative method of rate determination pursuant to COMAR 10.37.10.06. The Hospital requests approval from the HSCRC for participation in a global rate arrangement for the collection of peripheral blood stem cells from donors for a period of three years with the National Marrow Donor Program (NMDP) beginning July 1, 2010.

II. OVERVIEW OF APPLICATION

The NMDP, which coordinates the donation, collection, and transplantation of stem cells and bone marrow from unrelated donors for patients without matching donors in their families, proposes to use UMMC as a collection site for Department of Defense donors. The contract will 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 contract including payments to the Hospital and bear all risk relating to services associated with the contract.

III. FEE DEVELOPMENT

The technical portion of the global rates was developed based on historical hospital charge data relative to the collection of peripheral stem cells. The remainder of the global rate is comprised of physician service costs.

IV. IDENTIFICATION AND ASSESSMENT OF RISK

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

V. STAFF EVALUATION

The staff reviewed the experience for the last year under this arrangement and found that it was favorable. Staff believes that the Hospital can continue to 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 the collection of peripheral stem cells commencing July 1, 2010. The Hospital will need to file a renewal application for review to be considered for continued participation. Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospital for the approved contract. This document will formalize the understanding between the Commission and the Hospital, and will include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract 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:**	**2010**
MEDICAL CENTER	*	**FOLIO:**	**1879**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2069A**

Staff Recommendation

June 9, 2010

I. INTRODUCTION

University of Maryland Medical Center ("the Hospital") filed an application with the HSCRC on April 28, 2010 for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The Hospital requests approval from the HSCRC to continue to participate in a global rate arrangement for liver and blood and bone marrow transplants for a period of three years with Cigna Health Corporation beginning July 1, 2010.

II. OVERVIEW OF APPLICATION

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

III. FEE DEVELOPMENT

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

IV. IDENTIFICATION AND ASSESSMENT OF RISK

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

V. STAFF EVALUATION

The staff found that the Hospital's experience under this arrangement for the previous year was favorable.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospital's application for an alternative method of rate determination for liver and blood and bone marrow transplant services, for a one year period commencing July 1, 2010. The Hospital will need to file a renewal application to be considered for continued participation.

Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospital for the approved contract. This document would formalize the understanding between the Commission and the Hospital, and would include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, 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:**	**2010**
MEDICAL CENTER	*	**FOLIO:**	**1880**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2070A**

Staff Recommendation

June 9, 2010

I. INTRODUCTION

On May 14, 2010, the University of Maryland Medical Center ("UMMC" or the "Hospital") filed an application with the Commission for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The Hospital has requested approval to continue to participate in a global rate arrangement with the Gift of Life Foundation (GOL) for the collection of bone marrow and peripheral blood stem cells from GOL, on an outpatient basis, donors to facilitate Hematopoietic Stem Cell transplants into unrelated GOL recipients. The Hospital seeks approval of the arrangement for an additional year beginning April 1, 2010.

II. OVERVIEW OF APPLICATION

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

III. FEE DEVELOPMENT

The hospital portion of the global rates for the collection of bone marrow and peripheral blood stem cells has been developed based on recent historical charges for cases performed at UMMC. The remainder of the global rates comprised of physician services has been negotiated with the participating physician group.

IV. IDENTIFICATION AND ASSESSMENT OF RISK

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

V. STAFF EVALUATION

Staff found that the Hospital's experience under this arrangement for the last year was favorable.

VI. STAFF RECOMMENDATION

Because last year's experience was favorable, staff recommends that the Commission approve the Hospital's request for an alternative method of rate determination for the collection of bone marrow and peripheral stem cells for one year commencing April 1, 2010. UMMC will be required to file a renewal application for review to be considered for continued participation in the arrangement.

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 PARTIAL RATE	*	**BEFORE THE HEALTH SERVICES**	
APPLICATION OF	*	**COST REVIEW COMMISSION**	
SUBURBAN HOSPITAL	*	**DOCKET:**	**2010**
	*	**FOLIO:**	**1882**
BETHESDA, MARYLAND	*	**PROCEEDING:**	**2072R**

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Staff Recommendation

June 9, 2010

Introduction

On May 13, 2010, Suburban Hospital (the "Hospital") submitted a partial rate application to the Commission requesting a rate for Lithotripsy (LIT) services to be provided in-house. The Hospital currently has a rebundled rate for LIT services. The Hospital is requesting that the LIT rate be set at the statewide median with an effective date of July 1, 2010.

Staff Evaluation

The Hospital submitted its LIT costs and statistical projections for FY 2011 to the Commission in order to determine if the Hospital's LIT rate should be set at the statewide median rate or at a rate based on its own cost experience, Based on the information provided, staff determined that the LIT rate based on the Hospital's projected data would be $2,781.86 per RVU, while the statewide median for LIT services is $2,761.94 per RVU.

Recommendation

After reviewing the Hospital's application, the staff has the following recommendations:

1. That COMAR 10.37.10.07 requiring that rate applications be made 60 days prior to the opening of the new service be waived;
2. That the LIT rate of $ 2,761.94 per RVU be approved effective July 1, 2010;
3. That no change be made to the Hospital's Charge per Case standard for LIT services; and
4. That the LIT rate not be rate realigned until a full year's experience data have been reported to the Commission.

Final Recommendation for Revisions to the Reasonableness of Charges (ROC) Methodology

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June 9, 2010

This final recommendation was approved by the Commission on June 9, 2010. The Commission voted unanimously to rescind the 100% variable cost policy under recommendation #2 on November 3, 2010.

Background

ICC/ROC Methodology:

The Commission is required to approve reasonable rates for services offered by Maryland hospitals. The 'Reasonableness of Charges' (ROC) methodology is an analysis that allows for the comparison of charges at individual hospitals to those of their peer hospitals after various adjustments to the charge data have been applied. Hospitals with adjusted charges that are high compared to their peers are subject to rate decreases through spend-downs and/or negative scaling of the Update Factor. Conversely, hospitals with adjusted charges that are low compared to their peer hospitals may be allowed rate increases through positive scaling of the Update Factor based on their ROC position. The inter-hospital cost comparison (ICC) used for full rate reviews is based on the ROC methodology with additional adjustments for profit and productivity when establishing a peer standard for comparison. The ROC comparison is conducted annually in the spring or summer with ROC position scaling results impacting the July rate update for the following rate year.

ICC/ROC Workgroup:

Each year, the HSCRC solicits requests from the Maryland hospital industry for modifications to the ICC/ROC methodologies. A summary of the letters submitted on June 1, 2009 is included in Appendix A. Each fall, the ICC/ROC Workgroup, comprised of hospital, payer representatives and Commission staff, meets to discuss the ICC/ROC methodologies and the proposed modifications. This year, the ICC/ROC Workgroup met 13 times over a six month period and the following draft recommendations are the result of those deliberations.

This document represents the final set of recommendations associated with the ROC for 2010. Once approved by the Commission, these provisions will apply for both the application of ROC and ICC policy.

Issues and Draft Recommendations

1-Comprehensive Charge Target (CCT)

As approved by the Commission last year, the CCT is the starting point for the ROC methodology and is established by blending the inpatient charge per case (CPC) target and outpatient charge per visit (CPV) target. Implementation of the CPV was delayed until FY2011 and, therefore, CPV targets were not established for FY2010.

Recommendation: Staff recommends that the CPV used in the 2010 ROC be established as follows: Calculate a CPV for each hospital by using FY2009 outpatient data under the expanded CPV methodology that had been in place for FY2010. Inflate the established CPV by each hospital's outpatient rate update for FY2010 and blend the CPV and CPC targets to establish the CCT under the blending methodology approved last year.

Application of Indirect Medical Education (IME) and Disproportionate Share (DSH) Adjustment

Under the current ROC methodology, the IME and DSH adjustments are applied as a deviation from the statewide average. Therefore, using IME as an example, non-teaching hospitals with no IME costs

receive an upward adjustment to their CCT for the percent that they differ from the statewide average IME amount. Staff believes that it is technically correct and makes more intuitive sense to apply the costs associated with IME and DSH as a direct strip from hospital charges. Under this change, again using IME as an example, non-teaching hospitals would have no ROC adjustment for IME costs. At the end of last year's ICC/ROC Workgroup discussions, staff proposed this technical correction to the application of the IME and DSH adjustments. However, at that time, Workgroup members stated that it was too late in the discussion process to make this change.

Recommendation: Staff recommends the implementation of a technical correction to the IME and DSH adjustments that applies the adjustment as a direct strip instead of a deviation from the average statewide costs associated with IME and DSH.

2-Capital Adjustment

~~CareFirst and Kaiser proposed two changes to the HSCRC's policy on capital: 1) changes to the current capital adjustment in the ROC; and 2) a change to how capital is handled in rates in terms of the variable cost factor.~~

~~1) With regard to the ROC adjustment, the current methodology adjusts for the percentage of costs that are related to capital using 50% of the hospital-specific capital costs plus 50% of the statewide capital costs. CareFirst and Kaiser proposed a ten year phase-in to move from the 50/50 standard to 100% statewide costs plus 0.5%. At the end of the ten year phase-in period, there would be no ROC adjustment for capital. The purpose of this proposal is to gradually reduce the amount of capital provision that is specific to any individual institution and instead transition the system to a 100% prospective system plus an additional 0.5%. The additional 0.5% is an added factor to cover any and all unusual circumstances and to add a buffer for hospitals undertaking capital projects.~~

~~2) With regard to capital and the variable cost factor (currently at 85%), Care First and Kaiser proposed that Certificate of Need (CON) eligible projects be allowed to receive a different variable cost factor for three years after first use of a newly constructed facility. By proposing this policy change, CareFirst and Kaiser are attempting to recognize the difficulty faced by hospitals who undertook major capital projects just prior to the Commission's decision to move from a 100% variable cost adjustment to a more restrictive 85% variable cost adjustment for volume. Facilities who undertook these major projects when the variable cost factor was 100% were most certainly counting on these additional revenues as their volumes increased over time. Under the proposed policy change, the following variable cost factors would apply to hospitals as follows:~~

~~a) 100% variable cost adjustment if a hospital takes "the Pledge" to not file rate application;~~[1]

~~b) 100% variable cost if the CON for the project in question was filed when variable cost factor was 100% and hospital did not file a rate application;~~

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[1] The "Pledge" refers to circumstances where a hospital agrees not to request from the HSCRC an increase in rates greater than $1.5 million associated with a capital project over the life of that project. In exchange for this Pledge, the hospital is exempt from Certificate of Need (CON) review by the Maryland Health Care Commission.

c) 100% variable cost for hospitals that filed a CON when the variable cost factor was 85%, and the hospital did not file a rate application;

d) The current variable cost adjustment (85%) will be applied for hospitals that filed a rate application that generated additional dollars in rates for capital. Hospitals that filed a rate application and received additional funding in rates for their project through this process will not be eligible for the 100% variable cost adjustment.

Additional amounts provided to hospitals as a result of these circumstances, would be accounted for as slippage in future years system Update Factors – as per current Commission policy.

Staff response: Item 1) Staff is supportive of the concept of moving to a statewide standard for capital over a ten year period. A phasing out of the hospital-specific portion of capital in rates will provide the industry with stronger incentives to control costs and improve efficiency. Members of the ROC/ICC did not voice objection to this proposal.

Item 2) Staff also supports the idea of a less restrictive variable cost factor to fund capital projects in place of funding capital through rate increases. However, the staff would like to also recognize the impact that the policy change from 100% variable cost to 85% variable cost had on major capital projects. As noted, if a CON was filed and approved, along with the related comfort order, under the 100% variable cost policy, it was assumed the incremental margin on additional volume could be used to help fund the capital requirements. When the HSCRC changed the variable cost policy to 85%, this restricted hospitals ability to generate incremental margin on additional volume. In addition, staff would propose that the application of 100% variable cost factors to hospitals with major capital projects be extended on a forward-funded basis.

Recommendation:

Item 1) Staff recommends using a ten year phase-in to move from the current capital cost standard of 50% hospital-specific plus 50% statewide to 100% statewide plus 0.5%.

Item 2) Additionally, in an attempt to recognize the impact that the change in the variable cost policy had on major capital projects, the Staff recommends that certain CON eligible projects, where no rate application that generated additional dollars for capital has been filed would be eligible for three years of 100% variable cost.

2a) Original Proposal:
The three scenarios where 100% variable cost adjustment would apply to a hospital undertaking a major capital project and articulated in the original CareFirst/Kaiser proposal include:

a) New CON and the hospital agrees to take the pledge;

b) Previously filed CON, when the variable cost factor was 100%, and the hospital did not file a rate application;

~~c) Previously file CON, when the variable cost factor was 85%, and the hospital did not file a rate application.~~

~~Note: hospitals that filed rate applications and received funding through this process will continue to receive the current variable cost factor of 85%.~~

~~2b) Proposed Forward Funding Modification:~~
~~In addition to the requirements laid out in the baseline proposal above, the proposed forward funding modification would apply to the following hospitals (all falling under scenario b) above):~~

1. ~~Hospital must have an approved CON that was filed prior to the 85% variable cost policy change;~~
2. ~~Hospital must have a significant capital project, defined as:~~
   a. ~~Capital project in excess of 50% of the hospital's annual regulated gross patient revenue~~
3. ~~Hospital must be considered an efficient provider under the HSCRC's ROC methodology.~~

~~If the above qualifying criteria are met, the hospital would be eligible to forward-fund a portion of the projected volume adjustments. The forward-funding amount would be determined by the HSCRC staff after considering the following factors:~~

- ~~Cumulative volume adjustment applied to the hospital since 85% policy went into effect;~~
- ~~Cumulative volume adjustment applied to the state (average) for the same time period;~~
- ~~Anticipated volume changes over prospective three year period.~~

~~Eligible amounts would be forward funded to fiscal year of opening. Volume adjustments (calculated under the baseline proposal) ***in excess*** of the forward-funded amounts would be awarded in the future under the same timeline as the baseline proposal.~~

RECOMMENDATION #2 WAS RESCINDED BY COMMISSION ACTION ON NOVEMBER 3, 2010.

3-Profit and Productivity Adjustment in the ICC

The cost standard used for full rate reviews in the ICC methodology begins with the hospital's peer group ROC-adjusted CCT and then excludes the peer group's average profit, and includes a 2% productivity adjustment. The Maryland Hospital Association (MHA) contended that the current ICC policy is too restrictive for hospitals to access rate relief. The MHA proposed that during full rate setting the methodology should add back the lower of the target hospital's profit or 2.75% (the Financial Condition Policy's target for operating margins). The MHA also proposed that the 2% productivity adjustment be phased-in over a multi-year period, or that a national standard be identified and used for the productivity adjustment.

Hospital payment levels and costs have increased more rapidly in Maryland compared to the rest of the nation over the last 5 years. In FY05, Maryland was 2.58% below the U.S. in Net Operating Revenue per EIPA and moved to 1.90% above the U.S. in FY09 for this measure. For the same time period, Maryland went from 4.28% to 0.38% below the U.S. for Net Patient Revenue per EIPA and 3.65%

below to 0.71% above the U.S. for Cost per EIPA. Because of this erosion of Maryland hospital payments and costs compared to the U.S., staff believes that it would not be the appropriate time to move to a less restrictive standard in the ICC methodology.

Recommendation: Staff recommends no change to the profit and productivity adjustments in the ICC. However, during the deliberations of the ROC/ICC Work Group, representatives of the G-9 pointed out an apparent inconsistence between the HSCRC's policy for Partial Rate Applications (most specifically the Commission's policy regarding the profit strip for purposes of calculating the ICC standard) and the staff's new recommendation on phasing the system to 100% prospective capital (as recommended above in section 2, Item 1). As a result, the staff will consider appropriate changes to the HSCRC's Policy governing Partial Rate applications in next year's ROC/ICC review.

4 - Exclusions

Currently, liver transplants, heart and/or lung transplants, pancreas transplants, bone marrow transplants, and kidney transplants are excluded from the CPC constraint system because past analyses indicated that there was significant variation in charges within the corresponding APR-DRGs for these cases. Staff recently analyzed the charge variation for each of the transplant APR-DRGs using FY09 inpatient data. The liver, heart, pancreas, and bone marrow transplant cases continue to experience wide variations in charges and length of stay and should continue to be excluded from the CPC system. However, analyses of the kidney transplant cases indicate that there is very little variation in charges, as measured by the coefficient of variation, within the kidney transplant APR/SOI cells. At the March Commission Meeting, staff recommended that the kidney transplant cases be included under the CPC constraint system. In a meeting subsequent to the March recommendation, representatives from the Academic Medical Centers provided Commission Staff a more detailed review of the differences in costs associated with variations in recipient and donor types within the kidney transplant APR/SOI cells.

Recommendation: Staff recommends that kidney transplant cases continue to be excluded from the CPC constraint system in FY2011 pending a review of case mix issues raised by the Academic Medical Centers. Staff is hopeful this review will address any remaining case mix comparison issues such that some or all of the kidney transplant cases can be included in CPC constraint in FY 2012.

5 - Case-mix Lag

Under current Commission policy, case-mix is measured in "real time", meaning that the calculation of case-mix change for the previous rate year and calculation of the base CMI for the new rate order use discharge data from the July-June period immediately prior to the new rate year. For example, the base CMIs in the rate orders for the fiscal year that began July 1, 2009 were calculated using discharge data from July 1, 2008 thru June 30, 2009. Discharge data from the previous rate year is not available until, at the earliest, 4 months after the beginning of the new fiscal year. Therefore, the measurement of case-mix in real time causes unavoidable delays in issuing rate orders which, in turn, impacts hospitals' ability to achieve CPC compliance. Staff recommends that case-mix change and base CMI be measured using a three month lag in the data period. The data period used to calculate case-mix change for FY10 will remain the 12-months ending June 30, 2010. However, the base CMI for the FY11 rate orders will

be based on discharge data from April 1, 2009 – March 31, 2010 and case-mix change for FY11 will be measure using discharge data from April 1, 2010 – March 31, 2011. There are technical details associated with this change that Commission staff plan to discuss at MHA's Technical Issues Workgroup over the next several months.

Recommendation: Staff recommends incorporating a three month lag into the data periods used for case mix measurement. This change would go into effect the next rate year.

For rate year 2011, the reweighted base case mix index for the Charge per Case Targets for each hospital will be the twelve month period April 1, 2009 through March 31, 2010. Further, the case mix base and future measurement will incorporate the most current methodologies such as denials and one day stays. The case mix changes for rate year 2011 will be calculated for the twelve month period April 1, 2010 through March 31, 2011 and applied to the Charge per Case Targets to determine the case mix adjusted Charge per Case for rate year 2011 compliance purposes. The results will be incorporated into the rate orders effective July 1, 2011 (FY 2012).

Any technical implementation issues will be vetted with the MHA's Financial Technical Issues Task Force.

6 - Outlier Methodology

Under the current HSCRC high charge outlier methodology, a hospital-specific high charge outlier threshold is calculated for each APR/Severity cell. Charges above the established threshold are paid based on unit rates and not subject to the incentives of the HSCRC per case payment system.

The G-9 hospitals proposed a change to the HSCRC outlier methodology to address the following issues that they cite as consequences of the current methodology:

- Hospital charges could be structured to increase outlier charge levels
- Outlier patients are not protected by the financial incentives of the per case payment system
- Compliance with HSCRC rate orders are complicated by the segregation of outlier charges in compliance calculations

The G-9's proposed outlier methodology establishes a prospective allowance for outlier charges using a regression that is shown to predict each hospital's percentage of outlier costs with substantial accuracy. The following independent variables are used from previous year's data: the hospitals' proportion of vent cases, the hospitals' expected outlier proportion, and an AMC dummy variable. The result of the regression for each hospital would equal the hospital's outlier allowance for the succeeding year. A hospital's rate year CPC target would be increased by the prospective outlier allowance. In ROC comparisons, each hospital's target would be adjusted for the amount of the prospective outlier charges.

Although staff believes that certain aspects of the G-9 outlier proposal have merit, more study and deliberation is needed regarding this methodology.

Recommendation: Staff recommends the continuation of the current outlier methodology in FY2011.

7 - Peer Groups

The current peer group methodology uses 5 groups (based on size and location of hospital) for comparison including a virtual peer group for the Academic Medical Centers (AMCs). These peer groups were originally developed to adjust for differences in cost structures of hospitals which may not have been captured in the ROC adjustments used at that time. Because the Commission has implemented more refined adjustments for case-mix, labor market, and disproportionate share over the last several years, staff believes that this level of peer-grouping is no longer necessary. At the March Commission Meeting, staff proposed a move to three peer groups (major teaching, minor teaching, and non-teaching) based on the teaching intensity of the hospital as measured by residents per case-mix adjusted equivalent inpatient cases. In an ICC/ROC Workgroup meeting subsequent to the March recommendation, there was further discussion regarding the appropriate configuration of the two teaching peer groups. Because agreement was not reached regarding the appropriate division between major teaching and minor teaching, staff recommends that the current 5 peer groups be maintained. The payer representatives proposed that the Commission develop a national peer group for determination of reasonableness of charges for the Academic Medical Centers.

Recommendation: Staff recommends some modifications of the current peer group methodology for the spring/summer 2010 ROC. The proposed modifications seek to form peer groups that compare teaching hospitals to teaching hospitals and non-teaching hospitals to non-teaching hospitals, where-ever possible. These proposed modifications to the peer groups are as follows:

Unchanged Peer Groups: The State's two Academic Medical Centers will continue to be grouped in the existing "virtual" peer group that includes the 2 AMCs plus other large, urban, teaching facilities. This group is labeled "Peer Group 4 – AMC Virtual." The Urban and Urban teaching hospital group (which also includes Bon Secours hospital) will also remain unchanged. This group is no called, "Peer Group 3 – Urban Hospitals."

Changed Peer Groups: All non-teaching hospitals in the peer group previously referred to as Suburban and Rural Group 1 and smaller non-teaching hospitals (Atlantic General, McCready, Fort Washington, Memorial Easton, Dorchester and Chester River) previously in "Group 3," shall be grouped together in a group now labeled Group 2 - Suburban/Rural Non-Teaching Group 2. One teaching hospital (Baltimore Washington Medical Center), previously in Suburban/Rural Group 2 will now be moved to Non-Urban Teaching Group 1. The ROC results (reflecting these recommended modifications) are shown in **Appendix II**.

8 - ROC Scaling and Spend-Downs

At this time, staff recommends that the HSCRC not pursue spend-down arrangements with hospitals provided that the Commission approve a more aggressive ROC scaling methodology than has been applied in previous years. Scaling based on ROC rankings is an effective policy tool that rewards efficient hospitals (so called "stuck" hospitals – facilities that have been low on the ROC but otherwise unable to generate rate increases). Scaling also applies pressure to hospitals that have been high on the

ROC. But the reductions that result from year-to-year scaling are less onerous than rate reductions applied to hospitals under spend-downs.

In the past, the HSCRC has scaled 0.5% of revenue (on a revenue neutral basis). Staff recommends that a significant portion of revenue be scaled for ROC position, and that the structure of scaling be continuous. The Payment Workgroup will ultimately decide the amount of revenue to be scaled. Staff also recommends that the Total Patient Revenue (TPR) hospitals (McCready and Garrett) be eligible for positive ROC scaling but would not be negatively scaled.

Recommendation: Staff recommends that the amount of scaling for 2010 ROC results be significant and that the structure of the scaling be continuous. Staff also recommends that TPR hospitals should be eligible for positive scaling but not receive negative scaling based on ROC results. No spend-downs based on 2010 ROC results are recommended. If the Commission does not adopt a ROC scaling methodology that is more aggressive than what has been adopted in previous years, the staff would recommend the Commission initiate spend-down agreements with all hospital in excess of 3.0% above their peer group average.

Other On-going Activity

Physician Recruitment, Retention, and Coverage

A subset of community hospitals, known as G-9, offered a review of the costs associated with providing physician subsidies for physician recruitment, retention and coverage costs at hospitals in non-urban areas. The G-9 hospitals proposed that the Commission consider defining reasonable recruitment, retention, and coverage expenditures as elements of regulated hospital cost and adjust for these costs in the ROC in a manner similar to the direct medical education adjustment. Because physician services are not regulated by the HSCRC, staff does not agree that physician subsidies associated with recruitment, retention, and coverage should be considered elements of cost which are adjusted for in the ROC. However, staff agrees that the issue of physician subsidies and the impact on community hospitals needs further study.

Recommendation: Staff recommends no proposed adjustment in the ROC methodology associated with physician recruitment, retention, and coverage costs. Staff also recommends that a concerted study be initiated to better understand physician payments associated with physician recruitment, retention, and coverage at Maryland hospitals.

Development of a Peer Group for Academic Medical Centers (AMCs)

As noted, both the ROC and ICC methodologies contain a number of adjustments to hospital charges (case mix adjustment, labor market adjustment, direct strip, adjustment for Indirect Medical Education, etc.). These adjustments are necessary to ensure a fair comparison of hospital charges (the Commission has traditionally attempted to adjust for factors that influence hospital rates but that may be beyond the control of hospitals). The use of hospital peer groups (comparisons of hospitals that share similar characteristics) is another way the Commission has attempted to ensure a fair comparison of relative performance. This method of the use of extensive adjustments to hospital charges and peer group

comparisons has worked well for the implementation of the ROC and ICC over time. However, the State's two large Academic Medical Centers have consistently recommended that the HSCRC consider the development of a national peer group of other AMCs outside of Maryland, as the basis of a ROC and ICC comparisons for Johns Hopkins Hospital and University of Maryland. It is argued that comparing the State's two AMCs to other (non-AMC) teaching hospitals in Maryland does not adequately account for costs associated with the intensive teaching and research activities of AMCs.

Recommendation: Staff recommends that the HSCRC begin to investigate the possibility of establishing a national peer group of AMCs outside of Maryland as the basis of comparison for Johns Hopkins Hospital and University of Maryland. This investigation will determine the feasibility of this proposal (i.e. identifying the existence of necessary cost data and data required for any necessary adjustments). If after this investigation staff believes the establishment of a national peer group is feasible, it will establish a Work Group to assist it in this exercise.

Summary of Draft Recommendations for Changes to the ICC/ROC Methodology

Peer Groups: Staff recommends no change to the Virtual and Urban Peer groups. Staff further recommendations the formation of a Suburban/Rural Non-Teaching Peer group and a Non-Urban Teaching Peer Group as described in the body of the Recommendation and shown in Appendix II.

CPV in Blended CCT: Staff recommends that the CPV used in the 2010 ROC be established as follows: Calculate a CPV for each hospital by using FY2009 outpatient data under the expanded CPV methodology that had been in place for FY2010. Inflate the established CPV by each hospital's outpatient rate update for FY2010 and blend the CPV and CPC targets to establish the CCT under the blending methodology approved last year.

Application of IME and DSH Adjustment: Staff recommends the implementation of a technical correction to the IME and DSH adjustments that applies the adjustment as a direct strip instead of a deviation from the average statewide costs associated with IME and DSH.

Capital: Staff recommends using a ten year phase-in to move from the current capital cost standard of 50% hospital-specific plus 50% statewide to 100% statewide plus 0.5%. CON eligible projects would be allowed 100% of variable costs for three years after first use if hospital pledges to not file a rate application or if hospital filed CON previously and did not file rate application and pledges not to file in future.

Exclusions: Staff recommends that kidney transplant cases continue to be excluded from the CPC constraint system in FY2011 pending further review.

Case-mix Lag: Staff recommends moving to a 3-month lag in the data period used to measure hospital case-mix.

Outlier Methodology: Staff recommends the continuation of the current outlier methodology in FY2011.

Scaling and Spend-downs for 2010 ROC: Staff recommends that the amount of scaling for 2010 ROC results be significant and that the structure of the scaling be continuous. Staff also recommends that TPR hospitals should be eligible for positive scaling but not receive negative scaling based on ROC results. No spend-downs based on 2010 ROC results are recommended.

Physician Recruitment, Retention, and Coverage: Staff recommends that a concerted study be initiated to better understand physician payments associated with physician recruitment, retention, and coverage at Maryland hospitals.

Determining the Feasibility of Establishing a National Peer Group for AMCs: Staff recommendations it undertake an investigation of the feasibility of establishing a national peer group as the basis for the ROC and ICC comparison for Johns Hopkins and University of Maryland.

Appendix I

Summary of ICC/ROC Letters

The purpose of this document is to provide a brief overview of the issues addressed in letters submitted to the Commission June 1, 2009 regarding methodology issues to be discussed in the ICC/ROC Workgroup for the coming rate year.

Peer Groups

St. Joseph Medical Center requests that the current peer groups be replaced with a statewide comparison of hospitals.

Atlantic General requests a change from the current peer groups to a statewide group or teaching/non-teaching groups.

The hospitals in 'G-9' request that the current peer groups be considered for revision.

CareFirst and Kaiser Permanente request that there be just two peer groups: 1) a statewide peer group excluding the Academic Medical Centers; and 2) a national peer group for Johns Hopkins Hospital and the University of Maryland Medical Center.

MedStar Health and St. Agnes Hospital do not want peer groups eliminated but request that the current structure be reviewed to determine if the methodology meets the original goal.

Outlier Methodology

The Johns Hopkins Health System, University of MD Medical System, CareFirst and Kaiser request that the Commission staff revisit the outlier methodology to determine if the original objectives of this policy are being met and incentives are correct.

G-9 hospitals believe that the low charge outliers system is unnecessary, and that the incentives related to the payment for high charge outliers exacerbate the problem of complying with the waiver and, therefore, they support a review of the outlier policy.

Labor Market Adjustment

The Johns Hopkins Health System, the University of MD Medical System, and MedStar Health request a systemic review of the policy as well as suggest that a more detailed review of submitted data be put in place to ensure that the data are reasonable.

Disproportionate Share Adjustment

MedStar Health and St. Agnes Hospital request that the current DSH adjustment be re-assessed in order to confirm the measure's validity; to establish the stability over time; to understand if issues associated with urban locations are addressed; and to compare to possible alternatives.

Direct Medical Education

The Johns Hopkins Health System and the University of Maryland Medical System request that the current methodology for calculating the direct strip for DME (based on costs reported in the P4 and P5 schedules) is re-assessed due to vague P4 & P5 instructions related to ACGME approved residents and fellows which results in inconsistent reporting across hospitals.

Indirect Medical Education

CareFirst and Kaiser request that any future adjustments to the IME coefficient be based on the Commission's Update, and that the IME methodology be adjusted to support a greater amount of relative training of Primary Care Physicians who will provide care in Maryland.

Physician Coverage

The G-9 hospitals request that the differential accounting and treatment in ICC/ROC of the coverage costs at teaching hospitals (use of residents with costs carved out in DME adjustment) versus non-teaching hospitals (employed or subsidized attending staff costs not carved out) be addressed.

Partial Rate Review for Capital and Full Rate Reviews

CareFirst and Kaiser request that the partial rate process for capital be reviewed, and that the Commission consider transitioning to a statewide capital methodology that does not adjust rates for a hospital's position in its capital cycle.

The Johns Hopkins Health System and University of MD Medical System request that the partial rate process for capital be maintained; that a reasonable profit standard (2.75%) be included; and that productivity strips be eliminated from the partial rate and ICC methodologies.

The G-9 hospitals request that the criteria governing partial and full rate applications be reviewed by the Workgroup.

Scaling and Spend-Downs

CareFirst and Kaiser request an increase in the level of scaling next year and that spend-downs are resumed no later than July 1, 2010.

The G-9 hospitals request that the Workgroup review various approaches to scaling and spend-downs, including a discussion regarding the elimination of spend-downs.

Clinic Volumes

CareFirst and Kaiser request that clinic volumes, especially for multi-person behavioral health clinics, be reviewed.

Non-Comparable Services

CareFirst and Kaiser request that the Workgroup discusses objective methods of identifying and evaluating the cost of a particular service when that service differs substantially at a particular hospital compared to the peer group.

PPC Methodology

The G-9 hospitals request that the Workgroup consider issues associated with the implementation of the PPC methodology.

Case Mix Governor and Volume Adjustment

The G-9 hospitals suggest that the case-mix governor, in combination with the volume adjustment, places an undue financial burden on hospitals with both case-mix and volume increases, and that consideration should be given to handling case-mix and volume through a single measure of the hospitals' service level.

MedStar Health requests that policy decisions that impact the ROC, such as the case-mix governor, be evaluated.

Availability of Data

MedStar Health, Johns Hopkins Health System, and the University of MD Medical System request that future reports, such as those pertaining to the ROC and UCC, include the data used by staff to conduct its calculations and that a two-week comment period be implemented to allow hospitals the opportunity to correct the data in the event that errors are present.

Prospective Payment and System Stability

St. Joseph Medical Center, the Johns Hopkins Health System and the University of MD Medical System state that certain policies, such as case-mix restrictions without clear prospective rules for how case-mix will be accrued, undermine the prospective nature of the Maryland system. These hospitals also state that constant change in the system, such as revisions to the CPV to include more revenue or the proposed implementation of the PPC methodology, undermine the stability of the system.

Appendix II

Preliminary Summary of 2010 Maryland Hospitals' Reasonableness of Charges Comparison By Proposed Peer Groups

HOSPID	HOSPITAL NAME	ROC POSITION
PEER GROUP 1 - NON-URBAN TEACHING		-1.99%
210058	James Lawrence Kernan Hospital	4.02%
210022	Suburban Hospital	3.58%
210044	GBMC	2.66%
210043	Baltimore Washington Medical Center	-0.64%
210056	Good Samaritan Hospital	-0.97%
210011	St. Agnes Hospital	-1.11%
210004	Holy Cross Hospital	-1.46%
210015	Franklin Square Hospital Center	-1.95%
PEER GROUP 2 - SUBURBAN/RURAL NON -TEACHING		-1.64%
210045	McCready Memorial Hospital	53.71%
210051	Doctors Community Hospital	6.75%
210055	Laurel Regional Hospital	6.33%
210018	Montgomery General Hospital	5.76%
210061	Atlantic General Hospital	5.32%
210006	Harford Memorial Hospital	5.18%
210040	Northwest Hospital Center	5.17%
210054	Southern Maryland Hospital Center	4.45%
210030	Chester River Hospital Center	4.29%
210016	Washington Adventist Hospital	3.93%
210007	St. Joseph Medical Center	3.04%
210048	Howard County General Hospital	2.46%
210028	St. Mary's Hospital	2.27%
210027	Western Maryland Regional Medical Center	1.66%
210049	Upper Chesapeake Medical Center	1.41%
210019	Peninsula Regional Medical Center	0.04%
210060	Fort Washington Medical Center	-0.11%
210057	Shady Grove Adventist Hospital	-0.99%
210033	Carroll Hospital Center	-1.00%
210035	Civista Medical Center	-1.97%
210032	Union of Cecil	-5.26%
210023	Anne Arundel Medical Center	-5.43%
210039	Calvert Memorial Hospital	-5.55%
210005	Frederick Memorial Hospital	-6.39%
210001	Washington County Hospital	-6.65%
210037	Memorial Hospital at Easton	-8.99%
210017	Garrett County Memorial Hospital	-9.58%
210010	Dorchester General Hospital	-12.54%
PEER GROUP 3 - URBAN HOSPITALS		1.49%
210013	Bon Secours Hospital	6.55%
210012	Sinai Hospital	3.05%
210003	Prince Georges Hospital Center	2.44%
210024	Union Memorial Hospital	1.37%
210029	Johns Hopkins Bayview Medical Center	-1.82%
210008	Mercy Medical Center	-2.86%
210038	Maryland General Hospital	-3.98%
210034	Harbor Hospital Center	-4.23%
PEER GROUP 4 - AMC VIRTUAL		4.33%
210009	Johns Hopkins Hospital	4.38%
210002	University of Maryland Hospital	-0.02%

Addendum to the May Final Staff Recommendation Rate Methods and Financial Incentives relating to One Day Length of Stay and Denied Cases in the Maryland Hospital Industry

Method for Allocation of Unfunded Case Mix provisions for "early-adopter" Observation Unit Hospitals

Health Services Cost Review Commission
June 9, 2010

This final recommendation was approved by the Commission on June 9, 2010.

Introduction

At the May 5, 2010 Commission the HSCRC approved the final staff recommendation relating to the handling of One Day Stay cases and Denied Cases in the Maryland hospital rate setting system. **Appendix I** to this document provides an explanation of how these provisions will be implemented.

As discussed at the May 5 Public meeting of the HSCRC, the Maryland Hospital Association (MHA) requested additional time to gain a consensus position of Maryland hospitals regarding the reallocation of foregone case mix allowance by hospitals who were "early adopter" of medical observation units. As these hospitals established observation units, cases that had previously been admitted and treated on an inpatient basis were shifted to outpatient status. This had the effect of both reducing that hospital's overall "rate capacity" on remaining inpatient cases under their Charge per Case (CPC) target and also causing their measured inpatient case mix to increases. Because the HSCRC has imposed a limit on measured inpatient case mix in past years, many of these hospitals had some of all of this case mix increase governed away. Hospitals that have been slow to implement medical observation units were not victimized by these circumstances and have retained considerable revenues associated with excess rate capacity and ungoverned case mix.

Since the May HSCRC meeting the MHA did successfully gain a consensus of its members regarding the method to reallocate lost cases mix by the "early-adopter" hospitals. That methodology is described and presented in Appendix II to this recommendation. The copy of the email from MHA representative Mike Robbins is also included.

The MHA proposal focuses on outpatient observation coding as the basis for defining "early adopters" and only looks at medical observation cases. For 2008/2009, the total estimated rate relief for those hospitals would be approximately $29 million and restored to individual hospitals per the schedule shown on page 10 of the MHA presentation.

It was further recommended that this $29 million reallocation be revenue neutral to the rate setting system. This would mean that it should be accounted for as "system slippage" in future annual hospital inflation Updates (i.e., a portion of this $29 million would be reversed out of the approved update of every hospital).

While this method would assure revenue neutrality – several hospital representatives were concerned that this approach would erase much of the restoration provided to adopter hospitals ($29 million would be differentially allocated to a group of hospitals but then a pro-rata proportion of this $29 million would be taken away from all hospitals – including the early adopters).

The MHA's Council on Financial Policy thought that, if possible, perhaps some or all of this rate relief could be funded through savings that may have been realized in FY 2010 for actual case-mix being below what our budget was for this year. Current case mix growth over 3 quarters ending March 2010 at Level III (which includes growth in outliers and categorical excluded case revenue) is negative.

Staff would be receptive to this suggestion and recommend using this mechanism to fund the identified case mix restoration amounts by hospital (per page 10 of the document in appendix II) to the extent that

final FY 2010 case mix at Level III is less than the budgeted amount of case mix in the FY 2010 update factor of 0.5%.

Final Staff Recommendations

1) The Commission should utilize the MHA-Proposed method for reallocating lost Case-mix to hospitals who established observation units in previous years (the "early-adopters") and away from hospitals who have failed to establish observation capacity (methodology and calculation shown in **Appendix II**);

2) Should actual case mix growth for FY 2010 be less than the budgeted 0.5% case mix allowance per the approved FY 2010 update, then the $29 million in case mix restoration should be funded out of any "unspent" case mix provision. For instance, if final FY 2010 case mix at Level III shows 0% growth, then the full amount of the $29 million restoration can be accomplished by directly increasing the rates of the early adopters for their individual proportion of the calculated Case mix restoration. If final FY 2010 case mix at level three shows a 0.4% growth however, then only 0.1% of system inpatient revenue would be available (approximately $9 million) would be available for funding out of "unspent" case mix allowance and the balance of the $29 million would be handled through a slippage adjustment.

Appendix I – Procedures and Methods for Implementing the Approved Recommendation relating to One Day Stay Cases and Denied Cases

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE

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Memorandum

To: Maryland Hospitals

From: Robert Murray

Re: Implementation of Commission adopted One Day Length of Stay Recommendations

Date: June 2, 2010

The issue of the use of zero to one day length of stays (ODS) in Maryland has been the focus of discussion between both HSCRC staff and industry representatives for many months. The issue was raised in the context of:

- The national Medicare Recovery Audit Contractor ("RAC") initiative currently authorized by federal law to identify areas of both overpayment and underpayment to acute care hospitals by the Medicare program. ODS cases have been a particular area of focus for the RAC because of concern regarding whether or not these admissions meet Medicare's medical necessity criteria. A comparison of data on ODS nationally and in Maryland show Maryland admits 6% more one-day stays overall and 4% more Medicare one-day stay cases than hospitals in the rest of the US.

- During CY 2009, several private payers contacted HSCRC staff regarding the wide variation in the use of outpatient observation services by Maryland hospitals. These private payers believed that Maryland hospital practices were leading to an overuse of inpatient levels of care for patients that could be treated as observation cases. Overuse of inpatient services for cases that could be treated on an outpatient observation basis results in excess medical cost and potential additional clinical risks for patients.

- Over the summer of 2009 staff became aware of anomalous reporting and handling (for purposes of hospital Charge per Case development) of denied (based on medical necessity criteria) inpatient cases.

One Day Length of Stay Recommendations

After approximately six months of deliberation with the hospital and payer industries, on May 5, 2010, the Health Services Cost Review Commission ("HSCRC" or "The Commission") took the following action related to ODS cases at Maryland hospitals:

1. Exclude all One Day Stay (ODS) cases from hospitals' Charge per Case Standards effective July 1, 2010 (applying to the rate year FY 2011);
2. Do not explicitly link ODS impact to the Productivity Factor in the Update to Hospital Rates for FY 2011;
3. Utilize the method for reallocating lost Case-mix to hospitals who established observation units in previous years (the "early-adopters") and away from hospitals who have failed to establish observation capacity;
4. Adopt a set of "soft" (or desired) targets for Maryland hospital industry performance for Medicare and All-payer categories in terms of the number of ODS cases as a proportion of total admissions;
5. Apply an additional $10 million scaling incentive mechanism to continue to induce Maryland hospitals to appropriately shift ODS cases to ambulatory settings;
6. Adjust all hospitals' FY 2011 CPCs for the presence of denied cases that generate excess rate capacity that occurred beginning January 1, 2010;
7. Establish a separate Observation (OBV) Rate Center for FY 2011 and revise the current rate method for charging for Recovery Room time;
8. OBV cases and one-day surgical cases will be subject to the CPV starting in FY 2011;
9. exempt OBV cases from the application of any case mix cap imposed on outpatient cases (based on the final approved FY 2011 Rate Update Recommendation)

Implementation

Below are details on how each policy will be implemented:

1. Exclusion of ODS cases from CPC

There are both CPC compliance and Case Mix compliance issues associated with this removing ODS cases. Case Mix compliance will apply only to the remaining CPC cases after ODS cases are removed. In calculating the CPC for FY 2011, HSCRC will remove ODS cases from both the FY 2010 base and from the FY 2011 CPC. To calculate CMI for FY 2011, HSCRC will develop two CMIs: one which removes ODS cases during 6 months of FY 2010, and a second which will remove ODS cases for FY 2011.

A question arose regarding how the low trims would be treated under this scenario. Staff has determined that there is no need to continue to calculate a low trim since these charges are included in the ODS exclusions from the CPC.

2. **ODS Impact and the Productivity Factor of the FY 2011 Update**

The Commission will not link the productivity factor in the FY 2011 update to ODS cases.

3. **Reallocation of Case Mix based to early adopters of OBS units**

This issue will be considered by the Commission during the its June Public Meeting

4. **Soft Targets comparing Maryland and National trends on percentage of ODS cases**

The HSCRC will continue to access data from Medicare and all-payers in both Maryland and the nation to gauge Maryland's performance on the number of ODS cases as a proportion of total admissions compared to the nation. To compare Maryland ODS cases to national ODS cases, HSCRC staff will access the most recent data from the national Medpar file. There is a one year lag in the availability of data so CY 2009 data will be available by January 2011. In addition staff will utilize the most recent HCUP data (excluding newborns) to compare performance on an all-payer basis. Those data will be added to update the table below over time. The table below shows the aggregate targets out to 2014.

The recommendation adopted by the Commission establishes "soft targets" that would reduce Maryland's number of Medicare ODS cases and all-payer ODS cases by 1% per year beginning in FY 2011. The table below shows the aggregate targets out to 2014. The Commission did not adopt rewards or penalties based on these targets. Staff will continue to monitor both the performance compared to the nation and achievement relative to the expected 1% annual reduction.

Proposed "Soft Targets" for Maryland
Desired Performance on One Day Stay (ODS)
Cases as a Proportion of Total Admissions

Current Medicare Performance						Proposed "soft targets" for ODS cases			
	2006	2007	2008	2009	YTD 2010	2011	2012	2013	2014
Maryland	17.83%	17.59%	17.49%	17.50%	17.00%	**16.00%**	**15.00%**	**14.00%**	**13.00%**
US Medicare	13.75%	13.68%	13.40%	NA	NA				
Difference	4.08%	3.91%	4.09%						
Maryland All-Payer	22.48%	23.26%	22.82%	23.40%	23.05%	**22.05%**	**21.05%**	**20.05%**	**19.05%**
US All-Payer	16.58%	NA	NA	NA	NA				
Difference	5.90%								

NA = "Not Available"

5. **$10 million incentive scaling for shift in ODS cases to ambulatory settings**

The Commission adopted a $10 million incentive scaling approach which will adjust hospital revenue on an overall revenue neutral basis in FY 2012. The statewide standard will be based on data from FY 2010. FY 2011 cases will be used to determine individual hospital performance

(by APR/SOI) compared to the statewide standard from FY 2011.

The methodology will quantify the statewide average number of One Day LOS cases by APR/SOI cell in FY 2010. This will be the statewide standard for FY 2011 and hospitals can track their performance compared to this standard over the course of FY 2011.

Each hospital's number of One Day LOS cases by APR/SOI in FY 2011 will be compared to the statewide standard by APR/SOI for FY 2010. For each hospital, the actual number of One Day LOS cases would be subtracted from the statewide standard for each APR SOI to determine the excess number of One Day LOS cases in each APR/SOI.

An index is established based on each facility's overall comparison to the statewide standard and hospitals would be ranked based on this index. Based on the resulting index, $10 million would be scaled in FY 2012 on a revenue neutral basis so that high performers (in reducing One Day LOS cases) would receive additional revenue and poor performers would experience a reduction in revenue.

The calculation above would include medical and surgical cases with the exception of:

- Obstetric cases;
- Newborn cases;
- Transfers;
- Patients that left against medical advice; and
- Cases that resulted in death.

See Attachment I for a simulation using data from previous years.

6. FY 2011 CPC adjustment for the presence of denied cases after January 1, 2010

The FY 2011 CPC will be adjusted for denied cases that occur after January 1, 2010. HSCRC will match denied cases from the quarterly financial data to the case mix data tapes. Staff has identified inconsistencies in the reporting of denied cases. Please see Attachment II which outlines instructions on how to report these cases and HSCRC's plan to audit and, if necessary, fine hospital for noncompliance. Once matched, denied cases and charges occurring on or after January 1, 2010 will be removed from the financial data set and denied charges will also be removed from the case mix tapes to adjust the case mix weights. The HSCRC will then issue the FY 2011 CPC with these charges and cases removed.

7. Establish a separate Observation (OBV) Rate Center for FY 2011 and revision of the current rate method for charging for Recovery Room time

See Attachment III

8. OBV cases and one-day surgical cases will be subject to the CPV starting in FY 2011

Observation and one-day surgical cases, as identified in Attachment III, will be included in the

Charge per Visit Methodology beginning FY 2011.

9. Exemption of OBV cases from any case mix cap imposed on outpatient cases

If a case-mix governor is imposed on outpatient cases in FY 2011, hospitals will be held harmless for the increase in observation cases between FY 2010 and FY 2011. The hold harmless adjustment will be made in FY 2012. Staff will calculate the increase in the number of OBV cases between FY 2010 and FY 2011 at each hospital from the outpatient data set. If a hospital's OBV cases increased by 2% for example, HSCRC will make a 2% proportional adjustment to the hospital's outpatient case mix when determining the hospital's case mix amount for FY 2012.

Attachment I to Appendix I

Summary Results of the ODS Revenue Neutral Continued Incentive
Option 1: Scaling $10 Million of Statewide Inpatient Revenue (weaker incentives)

Hospital	ODS Index	Rank	Percentile Rank	Proposed Adjustment	Revenue Impact
Franklin Square Hospital	1.2431	1	0%	-0.1222%	($350,116)
Union Memorial Hospital	1.2403	2	4%	-0.1222%	($379,587)
Harford Memorial Hospital	1.187	3	6%	-0.0984%	($59,793)
Upper Chesapeake Medical Center	1.1727	4	8%	-0.0920%	($128,008)
Anne Arundel General Hospital	1.1307	5	10%	-0.0732%	($190,485)
Calvert Memorial Hospital	1.1278	6	12%	-0.0720%	($44,290)
Carroll County General Hospital	1.1069	7	14%	-0.0626%	($89,563)
Johns Hopkins Oncology Center	1.0921	8	16%	-0.0560%	($40,503)
Johns Hopkins Hospital	1.0816	9	18%	-0.0513%	($431,357)
Mercy Medical Center, Inc.	1.0774	10	20%	-0.0494%	($101,810)
Sinai Hospital	1.0753	11	22%	-0.0485%	($177,137)
St. Josephs Hospital	1.049	12	24%	-0.0368%	($107,125)
Baltimore Washington Medical Center	1.0296	13	27%	-0.0281%	($55,975)
Univ. of Maryland Medical System	1.0293	14	29%	-0.0280%	($156,705)
Garrett County Memorial Hospital	1.0213	15	31%	-0.0244%	($4,989)
Memorial Hospital at Easton	1.0185	16	33%	-0.0231%	($22,278)
Union Hospital of Cecil County	1.0116	17	35%	-0.0201%	($13,424)
Suburban Hospital Association,Inc	1.0104	18	37%	-0.0195%	($32,911)
Maryland General Hospital	1.0053	19	39%	-0.0172%	($23,874)
St. Agnes Hospital	1.0022	20	41%	-0.0159%	($39,859)
Howard County General Hospital	0.9761	21	43%	-0.0042%	($6,113)
Washington Adventist Hospital	0.9758	22	45%	-0.0041%	($8,834)
Good Samaritan Hospital	0.9621	23	47%	0.0034%	$7,075
Greater Baltimore Medical Center	0.9615	24	49%	0.0039%	$8,947
St. Marys Hospital	0.9569	25	51%	0.0073%	$4,872
Atlantic General Hospital	0.9448	26	53%	0.0163%	$6,196
Harbor Hospital Center	0.9086	27	55%	0.0433%	$65,227
Johns Hopkins Bayview Med. Center	0.9037	28	57%	0.0470%	$121,593
Doctors Community Hospital	0.9005	29	59%	0.0494%	$56,710
Washington County Hospital	0.8958	30	61%	0.0529%	$84,049
Laurel Regional Hospital	0.8904	31	63%	0.0569%	$35,207
Sinai Oncology	0.8835	32	65%	0.0620%	$18,313
Holy Cross Hospital of Silver Spring	0.8688	33	67%	0.0730%	$209,434
Prince Georges Hospital	0.852	34	69%	0.0855%	$152,378
Montgomery General Hospital	0.8479	35	71%	0.0886%	$88,799
Shady Grove Adventist Hospital	0.8448	36	73%	0.0909%	$194,061
Dorchester General Hospital	0.8378	37	76%	0.0961%	$28,987
Northwest Hospital Center, Inc.	0.8318	38	78%	0.1006%	$128,075
Peninsula Regional Medical Center	0.8291	39	80%	0.1026%	$269,514
James Lawrence Kernan Hospital	0.829	40	82%	0.1027%	$49,766
Western Maryland Regional Medical Center	0.8258	41	84%	0.1050%	$176,956
Civista Medical Center	0.8254	42	86%	0.1053%	$72,148
Southern Maryland Hospital	0.8157	43	88%	0.1126%	$177,144
Frederick Memorial Hospital	0.804	44	90%	0.1213%	$204,337
McCready Foundation, Inc.	0.7688	45	92%	0.1475%	$9,142
Chester River Hospital Center	0.7187	46	94%	0.1849%	$54,794
Fort Washington Medical Center	0.6989	47	96%	0.1997%	$47,216
Bon Secours Hospital	0.6931	48	98%	0.2040%	$152,133
University (UMCC)	0.4963	49	100%	0.2040%	$41,661
Statewide Total				0.0000%	$0

Attachment II to Appendix I

URGENT

May 6, 2010

To: Chief Financial Officers
From: Robert Murray, Executive Director
Re: Admission Denied for Medical Necessity - - Reporting

After reviewing the Admission Denied for Medical Necessity reports for the first two quarters of FY 2010, it appears that some hospitals may be under-reporting these cases. Since these cases will be excluded from the Charge per Case rate system, it is imperative that all cases be reported. In the event there may be some misunderstanding as to the cases to be reported, "Admission Denied for Medical Necessity" cases means: those cases, for all payers, where the inpatient admission has subsequently been denied for medical necessity, either self denied, denied after adjudication, or when the hospital does not contest the denial. This refers to those cases where **all of the inpatient routine room and board charges and the admission charge are denied.** Whether or not the hospital is reimbursed for ancillary services provided is not a factor. Several examples are attached as Exhibit A.

Hospitals submitting inaccurate or incomplete data may be subject to fines of up to $250 a day from the date that the report was due until complete and accurate data are **received**. However, Commission staff is providing hospitals the opportunity to review their records to be absolutely certain that they have reported all Admission Denied for Medical Necessity cases for the first two quarters of FY 2010. Revisions to the first two quarterly reports may be submitted without penalties on or before June 4, 2010. Additional cases may be included in the Third Quarter FY 2010 Report which is due on May 18, 2010.

If, after review of the Reports for the first three quarters of FY 2010 and any revisions received, the volume of cases at some hospitals still appears to be underreported, staff will require those hospitals to make available all of their data associated with denials for on-site review .

If you have any questions concerning the above, please contact Dennis N. Phelps, Associate Director-Audit & Compliance, at 410-764-2565.

Attachment III to Appendix I

April 29, 2010

To: Chief Financial Officers
From: Dennis N. Phelps – Associate Director, Audit & Compliance
Re: Establishment of an Observation Rate Center for Medical Observation Cases and Conversion of Same Day Surgery Rate Center

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The purpose of this memorandum is to notify hospitals of the process for establishing an Observation (OBV) rate center and the process to for converting their Same Day Surgery (SDS) rate effective July 1, 2010. The information needed to develop the OBV rate center and for the SDS conversion must be received in the HSCRC's offices on or before June 1, 2010, in conformance with the details stated below.

Overview

The purpose of OBV is to determine whether or not a patient should be admitted to the hospital as an inpatient. The decision to provide OBV should be solely a medical decision. OBV must be ordered and documented in writing by a medical staff practitioner. OBV services include the use of a hospital bed and periodic monitoring by nursing or other hospital staff in order to evaluate the patient's condition. Because of the nature of OBV, patients may enter through the Emergency Department (EMG) or may be directly admitted to OBV from a physician's office. OBV may be provided in a distinct unit or at any location within the hospital.

There is currently a way to charge for OBV, i.e., the costs associated with observation services are compiled in EMG, and OBV is charged as EMG services (one hour of OBV services equals 1.5 EMG RVUs). However, because reducing one-day cases will result in the provision of more outpatient observation cases, the HSCRC has decided, at the suggestion of the hospital industry, that a separate and distinct OBV rate center should be established effective July 1, 2010. Because one-day cases will be removed from the Charge per Case (CPC) system, the need to project how many one-day cases will become OBV visits in the future and to remove revenue and days from routine centers in setting up the OBV rate center has been eliminated. The most important issue in developing the OBV rate center is setting the OBV rate since, in most cases, the actual cost of an hour of OBV services will not be known until a full year's cost data are available.

Establishing a OBV Rate Center

The inconsistency in use of OBV services among Maryland hospitals dictates that there needs to be more than one methodology for the creation of the OBV rate center. For the purposes of establishing the OBV rate center, all hospitals fall into two general categories: 1) all hospitals that have been providing and charging for OBV services, i.e., they have been generating EMG units and revenue for OBV services; and 2) all hospitals that have not been providing OBV services or have been providing OBV services but not charging for them. Below you will find the methodology to be used in each case, with variations within each category. In addition, you will find the information that must be submitted in order to establish your hospital's new OBV rate

center. In the new OBV rate center, 1 hour equals 1 OBV RVU.

METHODOLOGIES

Category 1 - Hospitals that have been providing and charging for OBV services - **(Generating EMG units and revenue for OBV services.)**

Sub-categories:

A. Hospitals charging for OBV with all OBV costs in the EMG rate center (having accurately allocated OBV costs from routine centers):

1) Allocate OBV costs from EMG rate center based on EMG unit costs (unless there is a cost finding) and allocate OBV hours from EMG at 1 OBV hour

2) times 1.5 EMG RVU;

B. Hospitals charging for OBV that did not appropriately allocate all costs to EMG rate center:

1) Allocate new OBV units from EMG rate center (EMG RVUs times 1.5).

2) Allocate costs from EMG and routine rate centers based on cost finding **or allocate from both EMG and routine rate centers based on Hospital's Medical/Surgical (MSG) cost per unit (patient day)divided by 24.**

3) **Information to be provided to HSCRC: the rationale and supporting data for cost and unit of services reallocations, and a revised FY 2009 Schedule M so that the rate centers can be RATE REALIGNED in the IAS/PVPPI process.** New CPC and Charge per Visit (CPV) targets will be established based on the underlying costs.

The first year after creation of new OBV rate:

At same volumes, Hospital will generate less revenue in its EMG rate center and, if applicable, its routine centers based on allocation of costs; it will generate new revenue in OBV rate center.

Reconciliation of OBV rate to actual cost first year after creation of new OBV rate:

When FY 2011 cost data are available, determine whether FY 2011 OBV revenue generated is appropriate by comparing direct cost per actual OBV unit to direct cost per unit used to establish OBV rate. If OBV rate was

either understated or overstated, a one time revenue adjustment will be made to the Hospital's total rate base before rate realignment.

Category 2 - Hospitals that have not been providing OBV services or have been providing OBV services but not charging for them. **(No new revenue has been generated by OBV services. Rate centers where OBV costs have been reported have been overstated - - other rate centers understated)**:

1) In the absence of any historical data, the hospital's MSG rate divided by 24 should be used to set the OBV rate at a volume of 1.

2) Information to be provided to HSCRC: the rationale and supporting data for setting the OBV rate at other than the Hospital's MSG rate divided by 24. The new OBV rate can be established at the end of the Hospital's IAS/PVPPI process, since no volume or revenue is used to determine the new OBV rate, and the new rate will not affect the CPC and CPV targets.

First year after creation of new OBV rate center:

At same volumes, the Hospital will generate the same CPC revenue; however with the expected decreases in inpatient volumes, the routine centers will generate less revenue and CPC will have fewer cases, while generating new revenue in the OBV center.

Reconciliation of OBV rate to actual cost first year after creation of new OBV rate:

Use same methodology as in Category 1.

Surgical Cases – Same Day Surgery Recovery Services

The current structure of the Same Day Surgery (SDS) rate center is a fixed "per visit" charge per case for every outpatient surgical case. As part of the Commission's initiative to reduce the number of one-day stay cases, including surgical cases, more difficult cases will migrate from inpatient to outpatient. In order to allow for more appropriate matching of resource use to charges, the SDS rate must be tiered.

1) The Commission has decided to permit the SDS rate to be tiered. Hospitals will be required to tier their SDS based on a reasonable matching of resources utilized to the rate charged. If the recovery costs for outpatient surgical cases have not been appropriately allocated to the SDS rate center, costs may be allocated to SDS from other rate centers.

2) Information to be provided to HSCRC: the supporting data for cost reallocations, and a revised FY 2009 Schedule M so that the rate centers can be RATE REALIGNED in the IAS/PVPPI process.

Reconciliation of SDS rate to actual cost first year after conversion of SDS rate:
When FY 2011 cost data become available, determine whether FY 2011 OBV revenue generated is appropriate by comparing direct cost per actual SDS visit to the direct cost per SDS visit used to establish the SDS rate. If SDS rate was either understated or overstated, a one time revenue adjustment will be made to the Hospital's total rate base before rate realignment.

If you have any questions about the category that your hospital belongs in or technical questions about the methodologies, you may call me, Rodney Spangler or Chris O'Brien at 410-764-2605.

Appendix II – MHA Consensus Proposal for Reallocation of Case Mix for "early –adopter" hospitals

Robert Murray

From: Robbins, Mike [mrobbins@MHAONLINE.ORG]
Sent: Wednesday, May 26, 2010 1:15 PM
To: Robert Murray
Subject: "Early adopters" policy for HSCRC consideration at June meeting
Attachments: Observation Methodology for CFP - 051810.pdf

Bob,

As I mentioned to you last Friday, this e-mail is to follow-up with you regarding the consensus decision of MHA's Council on Financial Policy regarding a means to recognize the case-mix governor-associated revenues lost by hospitals that were "early adopters' of outpatient observation. I have attached for your information a copy of the presentation that was made by those hospitals that sought to amend our original proposal. As you will note, this proposal focuses on outpatient observation coding as the basis for defining "early adopters" and only looks at medical observation cases. For 2008/2009, the total estimated rate relief for those hospitals would be approximately $29 million. The CFP thought that, if possible, perhaps this rate relief could be funded through savings that may have been realized in FY 2010 for actual case-mix being below what our budget was for this year. In absence of your acceptance of that request, the CFP's position that this "early adopter" rate relief be funded through slippage on ALL hospitals.

I appreciate your consideration of this revised recommendation, and will be prepared to address this position at the June HSCRC meeting as needed. Thanks again for all of your help in fashioning this final ODS policy.

Mike

Michael B. Robbins
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Observation Services

Discussion of Alternative Methodology for Early Adopters

May 18, 2010

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Section 1

Background

Background

- Over the past year, the Health Services Cost Review Commission ("HSCRC") has been looking at one-day stays and observation services in Maryland
- The HSCRC has noted that hospitals in Maryland have a higher rate of one-day stays than the rest of the nation and less than half of the hospitals provide observation services
- The HSCRC asked the hospital industry to recommend a reasonable plan to incentivize hospitals to implement observation services and reduce one-day stays
- For early adopters, Observation services has resulted in a significant reduction in permanent rate capacity
  - Lower rate capacity for Observation services
  - By moving cases that would have resulted in a one-day inpatient stay to observation, the Hospital's lost revenue due to the governor

Background

- At the May 5, 2010 HSCRC public meeting, the Commission passed a number of measures relating to one-day stays and denied cases
- The MHA has a proposed methodology to credit hospitals for lost revenue due to the casemix governor on converted observation cases
- There are several concerns regarding the MHA proposal:
  - Assumes that the level of one-day stay cases is an accurate measure of observation services
  - The use of one days stays as a measure of medical observation has the potential to reward hospitals that did not provide Medical Observation services
  - All hospitals, including "early adopters" must fund the CMI restoration
- An alternative approach to address the "early adopters" is presented in this document

Section 2

Observation

Observation Methodology

- An alternative methodology would be to specifically identify Observation cases for 2007, 2008 and 2009 and corresponding casemix to determine actual impact on each Hospital's CMI

- Observation cases were identified for FY 2007, FY 2008 and FY 2009 using the following methodology:
  - Cases with ED charges
  - Cases with Revenue Code 760 and 762 (Observation) and charges > $0
    - Hospitals have been inconsistent reporting Observation CPT codes especially for 2007 and 2008
  - Excluded cases that grouped to MDC 14 – Pregnancy and Childbirth
    - This represent cases that would have Labor and Delivery Observation charges

Observation Methodology

- Cases were then grouped under APR-DRGs to determine the case mix if each observation case had been an inpatient case
  - Outpatient cases contain up to 15 diagnosis codes
  - Excluded cases that grouped to MDC 14 – Pregnancy and Childbirth
  - Excluded ungroupable cases for FY 2008 and FY 2009
    - Less than 1% of cases Statewide could not be grouped

- The impact of the Observation cases on the CMI Governor was calculated as follows:
  - For both FY 2008 and FY 2009, the CMI and corresponding change in CMI was calculated as if the Observation cases had been inpatient cases
  - A revised CMI Governor was calculated for each hospital based on the adjusted CMI change
  - The variance in the CMI Governor was then applied to the Hospitals rate base to determine the rate impact

Observation Cases

Hospital Number	Hospital	FY 2007 Excl. MDC 14		FY 2008 Excl. MDC 14		FY 2008 Excl. MDC 14		Incremental Cases Incremental Cases FY 2008		Incremental Cases Incremental Cases FY 2009	
		Cases	CMI	Cases	CMI	Cases	CMI	Cases	CMI	Cases	CMI
210001	Washington Cty. Hospital	1,630	0.3859	1,562	0.3766	1,638	0.3670	(68)	0.3766	76	0.3670
210002	U Of Md Hospital	168	0.4008	236	0.4557	304	0.3057	68	0.4557	68	0.3057
210003	Prince Georges Hosp. Ctr.	739	0.4066	727	0.4285	1,445	0.4064	(12)	0.4285	718	0.4064
210004	Holy Cross Hospital	3	0.4991	2,564	0.4202	2,711	0.4107	2,561	0.4202	147	0.4107
210005	Frederick Memorial Hospital	78	0.2565	-	-	1,361	0.4349	(78)	-	1,361	0.4349
210006	Harford Memorial Hospital	75	0.4805	71	0.4044	351	0.4648	(4)	0.4044	280	0.4648
210007	Saint Joseph Hospital	537	0.4034	839	0.4403	616	0.3602	302	0.4403	(223)	0.3602
210008	Mercy Medical Center	1,046	0.3206	1,352	0.3927	225	0.3797	306	0.3927	(1,127)	0.3797
210009	Johns Hopkins Hospital	1,776	0.4267	1,868	0.4221	2,781	0.4101	92	0.4221	913	0.4101
210010	Dorchester General Hospital	2	0.3618	3	0.3689	6	0.4341	1	0.3689	3	0.4341
210011	St. Agnes Heathcare	2	0.3757	22	0.4343	41	0.3776	20	0.4343	19	0.3776
210012	Sinai Hospital	140	0.2798	193	0.3968	136	0.3768	53	0.3968	(57)	0.3768
210013	Bon Secours Hospital	-	-	471	0.4218	317	0.4222	471	0.4218	(154)	0.4222
210015	Franklin Square Hospital	1,450	0.5621	1,453	0.3661	1,116	0.4944	3	0.3661	(337)	0.4944
210016	Wash. Adventist Hospital	294	0.3702	891	0.3547	892	0.3527	597	0.3547	1	0.3527
210017	Garrett Cty. Mem. Hospital	-	-	-	-	-	-	-	-	-	-
210018	Montgomery General Hospital	30	0.3995	34	0.3964	76	0.3698	4	0.3964	42	0.3698
210019	Peninsula Regional Med Ctr	19	0.5271	41	0.3709	28	0.3687	22	0.3709	(13)	0.3687
210022	Suburban Hospital	-	-	176	0.4551	419	0.4435	176	0.4551	243	0.4435
210023	Anne Arundel Med. Ctr.	795	0.3959	1,033	0.4206	1,490	0.4094	238	0.4206	457	0.4094
210024	Union Memorial Hospital	9	0.3536	118	0.4156	67	0.3525	109	0.4156	(51)	0.3525
210025	Memorial Of Cumberland Hosp.	-	-	-	-	-	-	-	-	-	-
210027	Sacred Heart Hospital	-	-	-	-	-	-	-	-	-	-
210028	St. Mary'S Hospital	100	0.2890	176	0.3916	198	0.2456	76	0.3916	22	0.2456
210029	Johns Hopkins Bayview Med. Ctr.	157	0.4211	1,051	0.4434	2,062	0.4389	894	0.4434	1,011	0.4389
210030	Chester River Hospital Center	-	-	-	-	-	-	-	-	-	-
210032	Union Of Cecil Hospital	-	-	-	-	-	-	-	-	-	-
210033	Carroll Cty. General Hospital	-	-	-	-	-	-	-	-	-	-
210034	Harbor Hospital Center	40	0.3404	94	0.4474	124	0.3916	54	0.4474	30	0.3916
210035	Civista Medical Center	4	0.4492	25	0.3408	180	0.3969	21	0.3408	155	0.3969
210037	Mem. Hosp. At Easton	261	0.3756	115	0.4435	105	0.3594	(146)	0.4435	(10)	0.3594
210038	Maryland General Hospital	-	-	-	-	-	-	-	-	-	-
210039	Calvert Memorial Hospital	82	0.4290	162	0.4277	189	0.3566	80	0.4277	27	0.3566
210040	Northwest Hospital Center	-	-	-	-	-	-	-	-	-	-
210043	Baltimore Washington Medical Center	1,620	0.3831	1,884	0.4603	1,997	0.3678	264	0.4603	113	0.3678
210044	Greater Baltimore Med. Ctr.	614	0.4809	3,341	0.4382	3,688	0.4772	2,727	0.4382	347	0.4772
210045	Mccready Memorial Hospital	-	-	-	-	1	0.5658	-	-	1	0.5658
210048	Howard Cty. General Hospital	1,488	0.4334	1,349	0.4049	1,642	0.4374	(139)	0.4049	293	0.4374
210049	Upper Chesapeake Medical Center	1,233	0.3761	276	0.3952	597	0.4469	(957)	0.3952	321	0.4469
210051	Doctors Community Hospital	1,378	0.3719	1,346	0.3785	1,514	0.3543	(32)	0.3785	168	0.3543
210054	Southern Maryland Hospital	-	-	860	0.4565	820	0.4176	860	0.4565	(40)	0.4176
210055	Laurel Regional Hospital	195	0.3690	328	0.4010	366	0.3878	133	0.4010	38	0.3878
210058	Kernan Hospital	-	-	-	-	-	-	-	-	-	-
210056	Good Samaritan Hospital	-	-	-	-	-	-	-	-	-	-
210057	Shady Grove Hospital	2,241	0.3488	2,658	0.3907	2,675	0.3896	417	0.3907	17	0.3896
210904	Johns Hopkins Oncology Center	-	-	19	0.4032	2	0.4601	19	0.4032	(17)	0.4601
210061	Atlantic General Hospital	-	-	-	-	-	-	-	-	-	-
210060	Fort Washington Medical Ctr.	-	-	-	-	-	-	-	-	-	-
218994	Umd (Cancer Center)	-	-	-	-	-	-	-	-	-	-
210080	Sinai - Oncology	-	-	-	-	-	-	-	-	-	-
	Total	18,206	0.4011	27,338	0.4134	32,180	0.4117	9,132	0.4333	4,842	0.4330

Case Mix Governor Impact Due to Observation

Hospital Number	Hospital Name	FY 2008	FY 2009	Total
210001	Washington Cty. Hospital	-	269,568	269,568
210002	U Of Md Hospital	219,985	729,561	949,547
210003	Prince Georges Hosp. Ctr.	-	-	-
210004	Holy Cross Hospital	2,871,402	-	2,871,402
210005	Frederick Memorial Hospital	-	4,070,614	4,070,614
210006	Harford Memorial Hospital	-	-	-
210007	Saint Joseph Hospital	-	-	-
210008	Mercy Medical Center	517,747	-	517,747
210009	Johns Hopkins Hospital	337,484	5,813,638	6,151,122
210010	Dorchester General Hospital	-	-	-
210011	St. Agnes Heathcare	5,445	86,062	91,506
210012	Sinai Hospital	147,572	-	147,572
210013	Bon Secours Hospital	767,809	-	767,809
210015	Franklin Square Hospital	-	-	-
210016	Wash. Adventist Hospital	-	-	-
210017	Garrett Cty. Mem. Hospital	-	-	-
210018	Montgomery General Hospital	5,491	145,194	150,685
210019	Peninsula Regional Med Ctr	-	-	-
210022	Suburban Hospital	83,159	1,030,229	1,113,387
210023	Anne Arundel Med. Ctr.	332,163	1,536,679	1,868,842
210024	Union Memorial Hospital	319,935	-	319,935
210025	Memorial Of Cumberland Hosp.	-	-	-
210027	Sacred Heart Hospital	-	-	-
210028	St. Mary'S Hospital	-	-	-
210029	Johns Hopkins Bayview Med. Ctr.	1,652,342	3,138,675	4,791,017
210030	Chester River Hospital Center	-	-	-
210032	Union Of Cecil Hospital	-	-	-
210033	Carroll Cty. General Hospital	-	-	-
210034	Harbor Hospital Center	67,403	101,861	169,264
210035	Civista Medical Center	27,747	429,043	456,790
210037	Mem. Hosp. At Easton	-	-	-
210038	Maryland General Hospital	-	-	-
210039	Calvert Memorial Hospital	-	64,499	64,499
210040	Northwest Hospital Center	-	-	-
210043	Baltimore Washington Medical Center	476,283	519,669	995,952
210044	Greater Baltimore Med. Ctr.	1,599,552	435,143	2,034,695
210045	Mccready Memorial Hospital	-	-	-
210048	Howard Cty. General Hospital	-	44,996	44,996
210049	Upper Chesapeake Medical Center	-	827,341	827,341
210051	Doctors Community Hospital	-	-	-
210054	Southern Maryland Hospital	-	-	-
210055	Laurel Regional Hospital	190,324	-	190,324
210058	Kernan Hospital	-	-	-
210056	Good Samaritan Hospital	-	-	-
210057	Shady Grove Hospital	546,144	47,654	593,799
210904	Johns Hopkins Oncology Center	87,679	-	87,679
210061	Atlantic General Hospital	-	-	-
210060	Fort Washington Medical Ctr.	-	-	-
218994	Umd (Cancer Center)	-	-	-
210080	Sinai - Oncology	-	-	-
	Total	$10,255,665	$19,290,427	$29,546,093

2008 Governor Impact of Observation Cases

		a	b	c	d	e	f	g = b + e	h = c	i = ((b*c)+(e*f))/g	j = d/c - 1	k = i/h - 1	l	m = [illegible]	n = (m - l)*a
			Actual			Observation Cases		Adjusted for Observation			CMI Change		CMI Governor		
Hospital Number	Hospital	CPC Revenue	Cases	Base CMI	Current CMI	Incremental Observation Cases	CMI	Cases	Base CMI	Current CMI	Original	Observation Adjustment	Original	Observation Adjustment	Revenue Impact
210001	Washington Cty. Hospital	$151,664,745	18,435	0.9611	0.9744	(68)	0.3766	18,367	0.9611	0.98	1.4%	1.6%	-0.5%	-0.5%	$0
210002	U Of Md Hospital	518,007,525	26,355	1.3371	1.3388	68	0.4557	26,423	1.3371	1.34	0.1%	0.0%	0.0%	0.0%	219,985
210003	Prince Georges Hosp. Ctr.	163,650,221	15,893	0.9742	0.9650	(12)	0.4285	15,881	0.9742	0.97	-0.9%	-0.9%	0.0%	0.0%	-
210004	Holy Cross Hospital	265,606,740	35,628	0.7897	0.8352	2,561	0.4202	38,189	0.7897	0.81	5.8%	2.2%	-1.8%	-0.7%	2,871,402
210005	Frederick Memorial Hospital	156,326,680	20,140	0.8955	0.9163	(78)	-	20,062	0.8955	0.92	2.3%	2.7%	-0.8%	-0.8%	-
210006	Harford Memorial Hospital	53,421,417	7,317	0.8226	0.8468	(4)	0.4044	7,313	0.8226	0.85	2.9%	3.0%	0.0%	0.0%	-
210007	Saint Joseph Hospital	274,995,712	25,472	1.2172	1.2108	302	0.4403	25,774	1.2172	1.20	-0.5%	-1.3%	0.0%	0.0%	-
210008	Mercy Medical Center	185,110,914	20,158	0.8889	0.9097	306	0.3927	20,464	0.8889	0.90	2.3%	1.5%	-0.8%	-0.5%	517,747
210009	Johns Hopkins Hospital	763,882,222	42,706	1.3427	1.3724	92	0.4221	42,798	1.3427	1.37	2.2%	2.1%	-0.7%	-0.7%	337,484
210010	Dorchester General Hospital	26,828,212	3,524	0.8972	0.8814	1	0.3689	3,525	0.8972	0.88	-1.8%	-1.8%	0.0%	0.0%	-
210011	St. Agnes Heathcare	219,309,087	21,673	1.0059	1.0361	20	0.4343	21,693	1.0059	1.04	3.0%	2.9%	-1.0%	-1.0%	5,445
210012	Sinai Hospital	335,188,608	26,704	1.1857	1.2029	53	0.3968	26,757	1.1857	1.20	1.5%	1.3%	-0.5%	-0.4%	147,572
210013	Bon Secours Hospital	62,506,575	6,597	0.9624	1.0478	471	0.4218	7,068	0.9624	1.01	8.9%	4.5%	-2.7%	-1.5%	767,809
210015	Franklin Square Hospital	276,029,716	30,154	0.8961	0.9121	3	0.3661	30,157	0.8961	0.91	1.8%	1.8%	-0.6%	-0.6%	-
210016	Wash. Adventist Hospital	208,841,610	20,217	1.0728	1.0696	597	0.3547	20,814	1.0728	1.05	-0.3%	-2.2%	0.0%	0.0%	-
210017	Garrett Cty. Mem. Hospital	19,987,666	2,998	0.7939	0.8328	-	-	2,998	0.7939	0.83	4.9%	4.9%	-1.6%	-1.6%	-
210018	Montgomery General Hospital	94,542,870	11,010	0.9006	0.9148	4	0.3964	11,014	0.9006	0.91	1.6%	1.6%	-0.5%	-0.5%	5,491
210019	Peninsula Regional Med Ctr	244,209,420	23,205	1.1843	1.2250	22	0.3709	23,227	1.1843	1.22	3.4%	3.4%	-1.1%	-1.1%	-
210022	Suburban Hospital	156,625,492	14,708	1.1702	1.1971	176	0.4551	14,884	1.1702	1.19	2.3%	1.5%	-0.6%	-0.5%	83,159
210023	Anne Arundel Med. Ctr.	227,504,385	28,671	0.9098	0.9300	238	0.4206	28,909	0.9098	0.93	2.2%	1.8%	-0.7%	-0.6%	332,163
210024	Union Memorial Hospital	294,770,430	20,690	1.3365	1.3767	109	0.4156	20,799	1.3365	1.37	3.0%	2.6%	-1.0%	-0.9%	319,935
210025	Memorial Of Cumberland Hosp.	68,314,400	8,800	0.8428	0.8394	-	-	8,800	0.8428	0.84	-0.4%	-0.4%	0.0%	0.0%	-
210027	Sacred Heart Hospital	78,242,218	9,277	0.9998	1.0205	-	-	9,277	0.9998	1.02	2.1%	2.1%	-0.5%	-0.5%	-
210028	St. Mary'S Hospital	67,147,824	10,792	0.6900	0.6847	76	0.3916	10,868	0.6900	0.68	-0.8%	-1.1%	0.0%	0.0%	-
210029	Johns Hopkins Bayview Med. Ctr.	235,465,342	22,421	0.9579	0.9798	894	0.4434	23,315	0.9579	0.96	2.3%	0.1%	-0.7%	0.0%	1,652,342
210030	Chester River Hospital Center	31,389,948	3,852	0.7891	0.8116	-	-	3,852	0.7891	0.81	2.9%	2.9%	-0.6%	-0.6%	-
210032	Union Of Cecil Hospital	65,668,142	9,266	0.8181	0.8104	-	-	9,266	0.8181	0.81	-0.9%	-0.9%	0.0%	0.0%	-
210033	Carroll Cty. General Hospital	130,020,669	17,219	0.8259	0.8750	-	-	17,219	0.8259	0.88	6.0%	6.0%	-1.8%	-1.8%	-
210034	Harbor Hospital Center	141,479,073	15,447	0.8816	0.9058	54	0.4474	15,501	0.8816	0.90	2.7%	2.6%	-0.9%	-0.8%	67,403
210035	Civista Medical Center	64,383,552	8,436	0.7876	0.8043	21	0.3408	8,457	0.7876	0.80	2.1%	2.0%	-0.7%	-0.6%	27,747
210037	Mem. Hosp. At Easton	85,878,684	10,908	0.8781	0.8736	(146)	0.4435	10,762	0.8781	0.88	-0.5%	0.2%	0.0%	0.0%	-
210038	Maryland General Hospital	132,652,300	12,694	0.9398	1.0174	-	-	12,694	0.9398	1.02	8.3%	8.3%	-2.2%	-2.2%	-
210039	Calvert Memorial Hospital	58,066,784	8,972	0.7275	0.7421	80	0.4277	9,052	0.7275	0.74	2.0%	1.6%	0.0%	0.0%	-
210040	Northwest Hospital Center	116,728,864	12,788	0.9732	0.9914	-	-	12,788	0.9732	0.99	1.9%	1.9%	-0.6%	-0.6%	-
210043	Baltimore Washington Medical Center	180,596,765	18,881	1.0631	1.0736	264	0.4603	19,145	1.0631	1.07	1.0%	0.2%	-0.3%	-0.1%	476,283
210044	Greater Baltimore Med. Ctr.	205,223,520	26,080	0.8875	0.9130	2,727	0.4382	28,807	0.8875	0.87	2.9%	-2.2%	-0.8%	0.0%	1,599,552
210045	Mccready Memorial Hospital	5,689,836	732	0.8147	0.7514	-	-	732	0.8147	0.75	-7.8%	-7.8%	0.0%	0.0%	-
210048	Howard Cty. General Hospital	132,692,280	16,805	0.8772	0.8782	(139)	0.4049	16,666	0.8772	0.88	0.1%	0.6%	0.0%	0.0%	-
210049	Upper Chesapeake Medical Center	127,443,960	17,304	0.8241	0.8280	(957)	0.3952	16,347	0.8241	0.85	0.5%	3.6%	-0.2%	-0.2%	-
210051	Doctors Community Hospital	103,470,666	11,622	0.9972	1.0137	(32)	0.3785	11,590	0.9972	1.02	1.7%	1.8%	-0.5%	-0.5%	-
210054	Southern Maryland Hospital	152,905,920	19,392	0.8401	0.8291	860	0.4565	20,252	0.8401	0.81	-1.3%	-3.2%	0.0%	0.0%	-
210055	Laurel Regional Hospital	60,746,460	7,230	0.8655	0.8983	133	0.4010	7,363	0.8655	0.89	3.8%	2.8%	-1.2%	-0.9%	190,324
210058	Kernan Hospital	45,039,380	2,764	1.6885	1.7397	-	-	2,764	1.6885	1.74	3.0%	3.0%	-1.0%	-1.0%	-
210056	Good Samaritan Hospital	196,924,574	17,066	1.2003	1.1949	-	-	17,066	1.2003	1.19	-0.4%	-0.4%	0.0%	0.0%	-
210057	Shady Grove Hospital	188,069,760	25,360	0.8323	0.8472	417	0.3907	25,777	0.8323	0.84	1.8%	0.9%	-0.6%	-0.3%	546,144
210904	Johns Hopkins Oncology Center	59,290,220	2,822	1.4671	1.5145	19	0.4032	2,841	1.4671	1.51	3.2%	2.7%	-1.0%	-0.9%	87,679
210061	Atlantic General Hospital	34,818,579	3,681	1.0305	1.0936	-	-	3,681	1.0305	1.09	6.1%	6.1%	-1.9%	-1.9%	-
210060	Fort Washington Medical Ctr.	21,650,574	2,903	0.8342	0.8728	-	-	2,903	0.8342	0.87	4.6%	4.6%	-1.5%	-1.5%	-
218994	Umd (Cancer Center)	13,926,825	825	1.3160	1.3889	-	-	825	1.3160	1.39	5.5%	5.5%	-1.8%	-1.8%	-
210080	Sinai - Oncology	32,541,914	1,486	1.5342	1.5877	-	-	1,486	1.5342	1.59	3.5%	3.5%	-1.1%	-1.1%	-
	Total														$10,255,665

2009 Governor Impact of Observation Cases

		a	b	c	d	e	f	g = b + e	h = c	i = ((b*c)+(e*f))/g	j = d/c-1	k = i/h-1	l	m = [illegible]	n = (m-l)*a
			Actual			Observation Cases		Adjusted for Observation			CMI Change		CMI Governor		
Hospital Number	Hospital	CPC Revenue	Cases	Base CMI	Current CMI	Incremental Observation Cases	CMI	Cases	Base CMI	Current CMI	Original	Observation Adjustment	Original	Observation Adjustment	Revenue Impact
210001	Washington Cty. Hospital	$154,156,699	18,181	0.9563	0.9666	76	0.3670	18,257	0.9563	0.96	1.1%	0.8%	-0.7%	-0.5%	$269,568
210002	U Of Md Hospital	549,257,256	26,968	1.3119	1.3398	68	0.3057	27,036	1.3119	1.34	2.1%	1.9%	-1.4%	-1.3%	729,561
210003	Prince Georges Hosp. Ctr.	174,466,776	16,284	0.9451	0.9517	718	0.4064	17,002	0.9451	0.93	0.7%	-1.7%	0.0%	0.0%	-
210004	Holy Cross Hospital	289,988,530	36,010	0.8181	0.8031	147	0.4107	36,157	0.8181	0.80	-1.8%	-2.0%	0.0%	0.0%	-
210005	Frederick Memorial Hospital	158,732,080	19,760	0.8946	0.9662	1,361	0.4349	21,121	0.8946	0.93	8.0%	4.2%	-5.4%	-2.8%	4,070,614
210006	Harford Memorial Hospital	61,804,864	7,744	0.8221	0.8085	280	0.4648	8,024	0.8221	0.80	-1.7%	-3.1%	0.0%	0.0%	-
210007	Saint Joseph Hospital	287,005,836	25,428	1.2031	1.2322	(223)	0.3602	25,205	1.2031	1.24	2.4%	3.1%	-1.3%	-1.3%	-
210008	Mercy Medical Center	200,013,354	20,946	0.9001	0.9183	(1,127)	0.3797	19,819	0.9001	0.95	2.0%	5.4%	-1.4%	-1.4%	-
210009	Johns Hopkins Hospital	819,782,788	42,746	1.3470	1.3612	913	0.4101	43,659	1.3470	1.34	1.1%	-0.4%	-0.7%	0.0%	5,813,638
210010	Dorchester General Hospital	28,822,092	3,666	0.8498	0.9119	3	0.4341	3,669	0.8498	0.91	7.3%	7.3%	-3.7%	-3.7%	-
210011	St. Agnes Heathcare	247,111,279	23,297	1.0234	1.0304	19	0.3776	23,316	1.0234	1.03	0.7%	0.6%	-0.5%	-0.4%	86,062
210012	Sinai Hospital	351,436,800	26,400	1.1871	1.2437	(57)	0.3768	26,343	1.1871	1.25	4.8%	4.9%	-3.2%	-3.2%	-
210013	Bon Secours Hospital	71,150,680	7,060	1.0186	1.0166	(154)	0.4222	6,906	1.0186	1.03	-0.2%	1.1%	0.0%	0.0%	-
210015	Franklin Square Hospital	284,686,766	30,331	0.8922	0.9116	(337)	0.4944	29,994	0.8922	0.92	2.2%	2.7%	-1.5%	-1.5%	-
210016	Wash. Adventist Hospital	201,633,804	19,414	1.0487	1.1007	1	0.3527	19,415	1.0487	1.10	5.0%	5.0%	-3.1%	-3.1%	-
210017	Garrett Cty. Mem. Hospital	18,642,689	2,851	0.8213	0.7986	-	-	2,851	0.8213	0.80	-2.8%	-2.8%	0.0%	0.0%	-
210018	Montgomery General Hospital	97,190,280	11,110	0.8930	0.8985	42	0.3698	11,152	0.8930	0.90	0.6%	0.4%	-0.4%	-0.3%	145,194
210019	Peninsula Regional Med Ctr	258,674,864	23,344	1.2063	1.2017	(13)	0.3687	23,331	1.2063	1.20	-0.4%	-0.3%	0.0%	0.0%	-
210022	Suburban Hospital	164,473,070	14,590	1.1839	1.1949	243	0.4435	14,833	1.1839	1.18	0.9%	-0.1%	-0.6%	0.0%	1,030,229
210023	Anne Arundel Med. Ctr.	251,657,780	29,945	0.9206	0.9675	457	0.4094	30,402	0.9206	0.96	5.1%	4.2%	-3.4%	-2.8%	1,536,679
210024	Union Memorial Hospital	305,677,719	20,547	1.3686	1.3947	(51)	0.3525	20,496	1.3686	1.40	1.9%	2.1%	-1.3%	-1.3%	-
210025	Memorial Of Cumberland Hosp.	71,386,434	8,694	0.8275	0.8457	-	-	8,694	0.8275	0.85	2.2%	2.2%	-1.2%	-1.2%	-
210027	Sacred Heart Hospital	86,739,302	9,358	0.9979	1.0250	-	-	9,358	0.9979	1.02	2.7%	2.7%	-1.8%	-1.8%	-
210028	St. Mary'S Hospital	68,805,184	10,724	0.6676	0.6444	22	0.2456	10,746	0.6676	0.64	-3.5%	-3.6%	0.0%	0.0%	-
210029	Johns Hopkins Bayview Med. Ctr.	252,791,700	21,900	0.9585	0.9763	1,011	0.4389	22,911	0.9585	0.95	1.9%	-0.6%	-1.2%	0.0%	3,138,675
210030	Chester River Hospital Center	31,079,290	3,685	0.7942	0.7827	-	-	3,685	0.7942	0.78	-1.4%	-1.4%	0.0%	0.0%	-
210032	Union Of Cecil Hospital	65,013,593	9,197	0.7889	0.8133	-	-	9,197	0.7889	0.81	3.1%	3.1%	-1.4%	-1.4%	-
210033	Carroll Cty. General Hospital	141,536,646	17,307	0.8543	0.8588	-	-	17,307	0.8543	0.86	0.5%	0.5%	-0.4%	-0.4%	-
210034	Harbor Hospital Center	146,926,750	15,385	0.8891	0.8900	30	0.3916	15,415	0.8891	0.89	0.1%	0.0%	-0.1%	0.0%	101,861
210035	Civista Medical Center	66,381,994	8,561	0.7862	0.8234	155	0.3969	8,716	0.7862	0.82	4.7%	3.8%	-3.2%	-2.5%	429,043
210037	Mem. Hosp. At Easton	91,080,496	11,192	0.8590	0.9727	(10)	0.3594	11,182	0.8590	0.97	13.2%	13.3%	-8.5%	-8.5%	-
210038	Maryland General Hospital	136,156,621	12,379	0.9890	0.9783	-	-	12,379	0.9890	0.98	-1.1%	-1.1%	0.0%	0.0%	-
210039	Calvert Memorial Hospital	61,483,422	9,178	0.7234	0.7428	27	0.3566	9,205	0.7234	0.74	2.7%	2.5%	-1.8%	-1.7%	64,499
210040	Northwest Hospital Center	123,960,888	12,744	0.9643	0.9935	-	-	12,744	0.9643	0.99	3.0%	3.0%	-2.0%	-2.0%	-
210043	Baltimore Washington Medical Center	194,270,213	19,507	1.0544	1.0987	113	0.3678	19,620	1.0544	1.09	4.2%	3.8%	-2.8%	-2.6%	519,669
210044	Greater Baltimore Med. Ctr.	228,626,496	25,816	0.8998	0.9023	347	0.4772	26,163	0.8998	0.90	0.3%	-0.3%	-0.2%	0.0%	435,143
210045	Mccready Memorial Hospital	5,713,929	669	0.7256	0.6907	1	0.5658	670	0.7256	0.69	-4.8%	-4.8%	0.0%	0.0%	-
210048	Howard Cty. General Hospital	140,478,096	17,328	0.8597	0.8601	293	0.4374	17,621	0.8597	0.85	0.0%	-0.8%	0.0%	0.0%	44,996
210049	Upper Chesapeake Medical Center	132,658,380	17,676	0.8123	0.8708	321	0.4469	17,997	0.8123	0.86	7.2%	6.3%	-4.8%	-4.2%	827,341
210051	Doctors Community Hospital	111,557,604	11,883	0.9892	0.9741	168	0.3543	12,051	0.9892	0.97	-1.5%	-2.4%	0.0%	0.0%	-
210054	Southern Maryland Hospital	152,276,540	18,980	0.8056	0.8405	(40)	0.4176	18,940	0.8056	0.84	4.3%	4.4%	-2.0%	-2.0%	-
210055	Laurel Regional Hospital	61,673,709	7,067	0.8726	0.8348	38	0.3878	7,105	0.8726	0.83	-4.3%	-4.6%	0.0%	0.0%	-
210058	Kernan Hospital	48,900,330	2,790	1.7717	1.6977	-	-	2,790	1.7717	1.70	-4.2%	-4.2%	0.0%	0.0%	-
210056	Good Samaritan Hospital	203,209,972	17,321	1.1764	1.1942	-	-	17,321	1.1764	1.19	1.5%	1.5%	-0.7%	-0.7%	-
210057	Shady Grove Hospital	207,201,117	26,843	0.8288	0.8391	17	0.3896	26,860	0.8288	0.84	1.2%	1.2%	-0.8%	-0.8%	47,654
210904	Johns Hopkins Oncology Center	70,457,656	2,986	1.4751	1.4548	(17)	0.4601	2,969	1.4751	1.46	-1.4%	-1.0%	0.0%	0.0%	-
210061	Atlantic General Hospital	37,993,402	3,791	1.0696	1.0751	-	-	3,791	1.0696	1.08	0.5%	0.5%	-0.3%	-0.3%	-
210060	Fort Washington Medical Ctr.	23,408,686	2,962	0.8523	0.8001	-	-	2,962	0.8523	0.80	-6.1%	-6.1%	0.0%	0.0%	-
218994	Umd (Cancer Center)	16,910,140	845	1.3457	1.4187	-	-	845	1.3457	1.42	5.4%	5.4%	-3.6%	-3.6%	-
210080	Sinai - Oncology	29,378,148	1,563	1.5513	1.6478	-	-	1,563	1.5513	1.65	6.2%	6.2%	-4.2%	-4.2%	-
	Total														$19,290,427

Section 3

Recommendations

Recommendations

- We recommend the following methodology:
  - Hospitals must provide evidence to the HSCRC of when they implemented Medical Observation services, including but not limited to a formal Observation policy
    - Hospitals either did or did not have Medical Observation services; take out the guesswork
  - Based on the calculation outlined, "early adopters" that provided Observation services should be allowed to recoup lost case mix due to the governor
  - After the "early adopters" are properly identified, the non-Observation hospitals would fund the CMI restoration
  - This alternative calculation would also apply to FY 2010 due to a continuance of a case mix governor for 2010 "early adopters"
  - Since one-day stay and denied cases will be excluded from the CPC methodology, no adjustment will be needed in FY 2011 and going forward

Community Benefit Background and Analysis

Background

- Nonprofit hospitals in the United States qualify for federal tax exemption from the Internal Revenue Service (IRS) if they meet certain requirements. The exemption is based on the principle that the government's loss of tax revenues is offset by its relief from financial burdens that it would otherwise have to meet with appropriations from public funds, and by the benefits resulting from the promotion of general welfare. In addition to federal income tax exemption, these hospitals also have access to charitable donations that are tax deductible to the donor and tax-exempt bond financing. Nonprofit hospitals may also be exempt under state law from state and local income, property, and sales taxes.

- IRS has not specified that nonprofit hospitals have to provide charity care to meet this requirement, but they must provide a benefit to the community. This has become known as the community benefit standard. In addition to charity care, services and activities that can qualify as community benefits include the provision of health education and screening to specific vulnerable populations within the community and activities that benefit the greater public good, such as education for health professionals and medical research.

- Many of these community benefit activities—especially charity care—are intended to benefit individuals who need financial and other help to obtain medical care.

Current Community Benefits Requirements and National Health Care Reform

- In 2005, GAO indicated that nonprofit hospitals nationally may not be defining community benefit in a consistent manner that would enable policymakers to hold them accountable for providing benefits commensurate with their tax-exempt status. Over recent years, several changes have been required on the federal level to attempt to remedy this.

- IRS requires entire IRS Schedule H (Form 990) to be filed by non- profit hospitals for tax year 2009 that:

  - Summarizes charity care policies
  - Documents their community benefits and community building programs
  - Identifies how they meet community healthcare needs
  - Describes other activities or characteristics that IRS associates with tax-exempt status
  - Distinguishes between charity care and bad debt

- Under the tax –exempt provisions in Health Care Reform, hospitals must:
    - Perform a community health needs assessment during either Tax Year 2011, 2012 or 2013, and:
        - conduct a needs assessment once every three years afterward;
        - adopt an implementation strategy to meet the community needs identified;
        - describe how the hospital is addressing the community health needs, if any needs are not being addressed and why; and
        - May be subject to a $50,000 tax imposable by IRS for each tax year that a hospital fails to meet the requirement of the Community Health Needs Assessment.
    - Adopt certain financial assistance policies (written policy must include: eligibility criteria, basis for calculating amounts charged to patients, method for applying assistance, actions hospital can take for non-payment (if there is not a separate collection policy);
    - Provide, without discrimination, care emergency services regarding of eligibility under their financial assistance policy.
    - Meet certain requirement on charges (prohibit use of "gross charges" to uninsured to "amounts generally billed to those who have insurance"); and
    - Meet certain billing and collection requirements (hospitals may not engage in "extraordinary collections actions" before making "reasonable efforts" to determine if patient qualifies for assistance).

Analysis of Hospitals based on FY 2009 CB Reports

Utilizing the data reported to the Commission, the attached spreadsheet compares hospitals on the total amount of community benefits reported, the amount of community benefits reported less community benefits provided in hospitals' rate structures, the number of staff

dedicated to community benefit operations, and information regarding community needs assessments. From the attached spreadsheet, the following observations can me made:

- On average, hospitals dedicated 774 hours during FY 2009 on community benefit operations. Fourteen hospitals report zero hours for this purpose. There is wide variation in the number of community benefit operations hours logged compared to the number of hospital employees.

- Hospitals reported providing $946.2 million in community benefits in FY 2009. The total amount of community benefits as a percentage of total operating expense ranges from 1.62% to 13.64% with an average of 7.6%. Six hospitals provided community benefits in excess of 10% of operating expenses while 7 hospitals provided less than 3%. In FY 2008, community benefits expenditures comprised of 7.22% of total hospital operating expenses.

- Charity Care, NSPI and DME costs are reported as community benefit costs but are included in hospital rates. When offsetting these amounts from the amount of community benefits reported:

    - A total of $453 million in net community benefits were provided in FY 2009; and

    - The average percentage of operating expenses dedicated to charity care drops to 3.64%. This percentage ranges from 0.13% to 9.75%.

- Only one hospital reported not conducting a formal or informal community needs assessment, while 25 hospitals conducted a formal assessment, 20 hospitals conducted an informal assessment, and one did not report on this question. 17 hospitals conducted a formal or informal needs assessment during the last 3 years (2007, 2008 or 2009). 3 hospitals indicated that they had not contacted their local health department regarding community health needs, and 4 hospitals did not make a statement regarding this question.

A Profile of Exemplary Community Benefit Programs

- Over the past five years, the quantitative community benefit reporting has made it difficult for policy makers to determine if community benefit spending was tied to needs identified within the community being served, whether the programs had been updated to meet the changing needs within the community, and whether hospitals were evaluating the effectiveness of their programs.

- Based on the addition of narrative reporting requirements beginning in FY 2009, hospitals are now required to answer specific questions about their community benefit activities. The narrative is focused on (1) how hospitals determined the needs of the communities they serve, (2) initiatives undertaken to address those needs, and (3) evaluations undertaken regarding the effectiveness of the initiatives. The intent was to encourage hospitals unable to answer questions about their programs, due to lack of process or evaluation, to begin to focus their attention on planning and evaluation.

- Most hospitals were able to report that they used a needs assessment process, either formal or informal, in determining what community benefit activities would be undertaken. Many of those hospitals were able to identify the initiatives they have undertaken, however only some hospitals were able to report that they had completed evaluations of their initiatives.

- Five hospitals whose reports stand out as exemplary are:

  1. Calvert Memorial Hospital
  2. Carroll Hospital Center
  3. Franklin Square Hospital Center
  4. Holy Cross Hospital
  5. Johns Hopkins Bayview

- See highlights attached

Hospital Name	Employees	Total Staff Hours CB Operations Reported	Total Hospital Operating Expense	Total Community Benefit	Total CB as % of Total Operating Expense	FY 2009 Amount in Rates for Charity Care, DME and NSPI	Total Net CB Benefit minus Charity Care, NSPI, DME in Rates	(minus Charity Care, NSPI, DME in rates) as % of Op. Expense	CB Reported Charity Care	formal/ Informal needs Assessment by hospital or health department	Year of Most Recent Needs Assessment	contact with local health department
Anne Arundel	3000	312	$392,109,000	$9,813,130	2.50%	$5,198,679	$4,614,451	1.18%	$4,872,100	informal	not stated	yes
Atlantic General	698	89	$78,925,917	$4,025,228	5.10%	$871,169	$3,154,059	4.00%	$1,016,205	informal	2005	yes
Baltimore Washington	2578	60	$273,937,000	$6,697,686	2.44%	$6,339,523	$358,163	0.13%	$4,892,037	formal	2008	yes
Bon Secours	847	0	$135,615,987	$15,054,505	11.10%	$6,691,935	$8,362,570	6.17%	$8,647,745	informal	1998	yes
Calvert Memorial	1074	205	$116,764,179	$9,450,809	8.09%	$1,436,065	$8,014,744	6.86%	$1,500,565	formal	2007	yes
Carroll Hospital	1763	5870	$187,169,454	$18,089,190	9.66%	$6,262,908	$11,826,282	6.32%	$5,210,626	formal	2005	yes
Chester River	479	0	$56,362,775	$5,449,333	9.67%	$2,026,384	$3,422,949	6.07%	$2,825,000	formal	2008	yes
Civista	674	2866	$103,915,231	$3,370,461	3.24%	$1,643,760	$1,726,701	1.66%	$1,727,048	formal	2006	yes
Doctors	1356	80	$174,268,710	$3,514,706	2.02%	$851,574	$2,663,132	1.53%	$793,669	informal	not stated	no
Fort Washington	446	0	$43,524,509	$991,509	2.28%	$458,567	$532,942	1.22%	$664,274	informal	2006	yes
Franklin Square	3260	3962	$382,897,946	$28,153,523	7.35%	$17,700,956	$10,452,567	2.73%	$8,355,104	formal	2008	yes
Frederick Memorial	2062	0	$288,949,000	$16,975,445	5.87%	$5,308,737	$11,666,708	4.04%	$5,877,400	formal	2007	yes
Garrett County	341	163	$35,576,162	$2,217,305	6.23%	$1,596,736	$620,569	1.74%	$1,898,950	informal	2008	yes
GBMC	3000	0	$370,628,005	$14,929,004	4.03%	$7,623,830	$7,305,174	1.97%	$3,116,159	informal	2006	no
Good Samaritan	2411	2507	$289,772,684	$18,204,682	6.28%	$9,671,720	$8,532,962	2.94%	$4,268,699	informal	not stated	yes
Harbor Hospital	1495	353	$188,476,023	$16,275,390	8.64%	$9,117,770	$7,157,620	3.80%	$4,734,700	informal	not stated	yes
Holy Cross	3068	4109	$367,349,737	$30,076,895	8.19%	$12,401,502	$17,675,393	4.81%	$12,358,868	formal	2006	yes
Howard County	1744	152	$207,441,000	$12,492,416	6.02%	$1,837,044	$10,655,372	5.14%	$1,665,942	formal	2001	yes
JH Bayview	3531	320	$518,619,000	$56,434,372	10.88%	$42,483,497	$13,950,875	2.69%	$28,265,000	formal	2008	yes
Johns Hopkins	9600	3890	$1,556,118,000	$145,328,708	9.34%	$106,484,109	$38,844,599	2.50%	$37,024,000	formal	2005	yes
Kernan	655	116	$95,194,646	$5,291,660	5.56%	$3,614,799	$1,676,861	1.76%	$547,000	informal	2005	not stated
Laurel Regional	562	0	$90,274,400	$8,811,405	9.76%	$410,197	$8,401,208	9.31%	$338,565	no	n/a	none
Maryland General	1060	552	$183,911,000	$12,614,678	6.86%	$8,489,187	$4,125,491	2.24%	$4,830,000	informal	2008	yes
McCready	300	35	$14,619,162	$1,241,040	8.49%	$605,390	$635,650	4.35%	$968,730	formal	2005	yes
Mercy	3304	200	$344,923,000	$41,018,475	11.89%	$14,129,383	$26,889,092	7.80%	$9,829,267	informal	2008	yes
Montgomery General	1340	3	$122,776,400	$9,260,951	7.54%	$4,960,483	$4,300,468	3.50%	$4,809,700	informal	2006	yes
Northwest	1561	0	$190,488,000	$8,842,633	4.64%	$4,860,821	$3,981,812	2.09%	$5,295,000	formal	2005	yes
Peninsula	2683	115	$357,978,000	$14,452,339	4.04%	$6,947,716	$7,504,623	2.10%	$8,145,900	formal	2005	yes
Prince George's	1591	27	$244,485,900	$18,529,658	7.58%	$4,634,292	$13,895,366	5.68%	$1,032,020	formal	2006	yes
Saint Agnes	3307	0	$358,103,038	$29,791,139	8.32%	$18,738,638	$11,052,501	3.09%	$13,158,163	formal	2007	yes
Saint Joseph	2633	0	$358,442,985	$5,801,060	1.62%	$3,054,692	$2,746,368	0.77%	$4,018,865	formal	2006	yes
Saint Mary's	1136	53	$114,970,861	$6,936,725	6.03%	$4,259,296	$2,677,429	2.33%	$3,365,310	informal	2007	yes
Shady Grove	1942	823	$275,607,577	$29,585,432	10.73%	$8,341,197	$21,244,235	7.71%	$9,373,977	informal	2007	yes
Shore Health - Easton	1290	0	$134,106,845	$8,571,170	6.39%	$2,609,773	$5,961,397	4.45%	$3,109,636	informal	not stated	not stated
Shore Health -Dorchester	617	0	$43,095,616	$3,191,311	7.41%	$1,254,054	$1,937,257	4.50%	$1,220,210	informal	not stated	not stated
Sinai	4350	2808	$632,373,000	$30,633,923	4.84%	$23,426,941	$7,206,982	1.14%	$10,634,840	formal	2005	yes

Hospital Name	Employees	Total Staff Hours CB Operations Reported	Total Hospital Operating Expense	Total Community Benefit	Total CB as % of Total Operating Expense	FY 2009 Amount in Rates for Charity Care, DME and NSPI	Total Net CB Benefit minus Charity Care, NSPI, DME in Rates	(minus Charity Care, NSPI, DME in rates) as % of Op. Expense	CB Reported Charity Care	formal/ Informal needs Assessment by hospital or health department	Year of Most Recent Needs Assessment	contact with local health department
Southern Maryland	1636	0	$222,131,545	$16,410,869	7.39%	$1,228,201	$15,182,668	6.83%	$1,469,042	not stated	not stated	not stated
Suburban	1600	1426	$230,094,500	$15,783,345	6.86%	$4,250,567	$11,532,778	5.01%	$4,337,800	informal	not stated	yes
UCH-Harford	773	153	$87,176,000	$2,425,992	2.78%	$1,100,816	$1,325,176	1.52%	$1,451,597	formal	2005	yes
UCH-Upper Chesapeake	1724	356	$179,314,000	$3,258,554	1.82%	$1,861,960	$1,396,594	0.78%	$2,045,004	formal	2005	yes
Union Cecil County	1022	210	$124,492,414	$4,027,521	3.24%	$1,403,035	$2,624,486	2.11%	$1,690,600	formal	2004	yes
Union Memorial	2420	85	$392,085,514	$32,579,081	8.31%	$20,831,264	$11,747,817	3.00%	$8,141,892	informal	not stated	yes
University of Maryland	5937	3622	$1,119,376,000	$152,667,507	13.64%	$84,567,844	$68,099,663	6.08%	$43,218,000	formal	2008	yes
Washington Adventist	1550	634	$257,235,122	$33,062,153	12.85%	$7,989,907	$25,072,246	9.75%	$9,862,543	informal	2007	yes
Washington County	2211	231	$243,536,900	$21,825,141	8.96%	$7,575,529	$14,249,612	5.85%	$10,028,718	formal	2008	yes
WMHS -Cumberland	1025	0	$103,074,694	$5,076,058	4.92%	$3,520,688	$1,555,370	1.51%	$2,365,487	formal	2009	yes
WMHS-Braddock	1315	0	$154,440,387	$7,004,047	4.54%	$2,602,149	$4,401,898	2.85%	$4,719,883	formal	2009	yes
total	92971	36387	$12,442,727,824	$946,238,164	7.60%	$493,275,288	$452,962,876	3.64%	$309,721,840			
Average	1978	774										

	Calvert Memorial Hospital
Identification of Needs:	**comprehensive community health assessment**
	community health forum
	surveys
	updated medical staff plan with analysis
	strategic planning process
	involvement of local health department
Decision Making Process:	**Board of Directors, CEO, Department directors, President's Panel (staff representative of all major hospital departments), Executive Team**
Program:	**Need: Lack of Pediatric Dental Care for Medicaid Population**
	Program: Contract dental providers in existing underutilized dental space with hospital as billing agent and program coordinator.
	Evaluation: grant received FY09; program guidelines completed; relationships with area dentists developed; contracts for leasing space completed; staff hired and trained; targed advertising; patients identified and provided services; formal evaluation after one year of grant funding, informal evaluation after each session; patients are now receiving dental care.
Program:	**Need: Care for uninsured.**
	Program: Calvert HealthCare Solutions - utilizes existing medical resources in the community to provide primary care to the uninsured who meet income qualification guidelines. Patient is provided a case manager, basic lab and xray diagnostic tests at no cost. (provided over 70,339 in services fy09.
	Evaluation: 16 specialty providers recruited; 213 new clients enrolled; 362 physician office visits; 32 sliding scale patients initiated care at clincs; 613 patients from ER contacted by case management and 85 obtained follow-up care; 1 patient received 7 mental health visits. Evaluation led to incorporation of RN care coordinator to provide medication, wellness, and nutrition counseling; disease prevention coaching; diabetic self management classes; improvements to database and tracking system.

	Carroll Hospital Center
Identification of Needs:	**health status assessment projects with Partnership for a Healthier Carroll County**
	Healthy Carroll Vital Signs-Measures of Community Health -data collection
	Elder Needs Health Assesment
Decision Making Process:	**Patients; Partnership for Healthier Carroll County; The Learning Center; The Women's place; Marketing and Business Development; hospital's multidisciplinary Community Benefit Planning and Review Team; hospital's executive team and Board of Directors**
Program:	**Need: Adult education regarding obesity and associated health risks.**
	Program: Lose to Win Program - twelve week collaborative community program to promote weight loss and wellness. 12-week program - unlimited access to exercise sessions at Merritt Athletic Club; weekly group nutritional classes at Martin's Food Market; Weekly weigh-ins and blood pressure checks; pre and post program blood profiles.
	Evaluation: 20 out of 21 people completed 12 week program; group lost total of 340 lbs; 15 people had reduction in body fat; 13 people had reduction in total Cholesterol, LDL - 8, Triglycerides - 14 people; 3 significantly reduced blood surgar and blood sugar control
Program:	**Need: access to high-quality prenatal, labor and delivery, and in-hospital newborn care at affordable cost.**
	Program: Best Beginnings Program-provide women without health insurance access to quality prenatal, labor and deliver and newborn care to those who would not have access to such services. Joint effort between hospital and affiliated physicians.
	Evaluation: 35 patients provided care in FY 2009; all mothers had successful deliveries with newborns at or over normal birth weight; increase from 2008 - 2009 of women treated in first trimester instead of later in pregnancy. FY 2009 -66 % enrolled in first trimester vs. FY 2008 - 16% enrolled in first trimester.

	Franklin Square Hospital Center
Identification of Needs:	**Community needs assessment of southeastern portion of Baltimore County; development of action plan; consultation with health department**
Decision Making Process:	**Hospital Board Community Awarness Committee; community service line director; community outreach manager; community RN education specialists.**
Program:	**Need: Domestic Voilence prevention**
	Program: Child Abuse Prevention Services - over 300 children suspected of being abused per year are evaluated at Franklin Square. Evaluations based on comprehensive approach developed by Department of Pediatrics. Instituted CPT (child protection team) with a social worker coordinator, medical director, on-call social work and medical staff; 24/7 coverage and evaluated any child suspected of being abused. Abusive Head Trauma prevention education; Infant safe sleeping program
	Evaluation: Increased number of infants presenting at ED are evaluated for abuse; 84 % of cases referred to Social services have been accepted for investigation due to improved evaluative process much higher than on national level; increased parental education and committment to learning coping mechanisms to lower rate of shaken baby syndrome. - Plan: Continue program and use as a model for new programs.
Program:	**Need: Healthcare for the Homeless**
	Program: Partnered with Baltimore County and Healthcare for the Homeless in Baltimore City to establish a new access point for primary care for people experiencing homelessness in Baltimore County. In recent years, 7000 people have been identified as homeless in Baltimore County with 71% being women and children and 45% reporting no health insurance; Chronic issues include: mental and addictive disorders, hypertension, diabetes, HIV/AIDS;
	Evaluation: partnership establishes a medical home for vulnerable county residents; provides preventive health services before health issues escalate into an emergency. Additional funding is being sought to meet needed resources (space, specialty care, medications). Since inception in 2006, over 700 people have benefitted from over 3,500 primary care visits. 55% are temoporarily housed in the family shelter.

	Holy Cross Hospital
Identification of Needs:	**participation in community coalitions, partnerships, boards, committees, commission, advisory groups, panels; quarterly analysis of internal patient surveys and public market data; review of local needs assessments and reports; consultation with local health department**
Decision Making Process:	**Hospital's interdepartmental leadership, executive management, board of trustees plan monitor and evaluate hospital's community benefit effort; chief executive officer review committee on community benefit(internal, interdepartmental committee) Community leaders**
Program:	**Need: provide health education, disease prevention and chronic disease management (including obesity)programs to improve the health status of the community.**
	Program: Maternal and Child Health Initiative: Kids Fit. In partnership with Housing Opportunities Commission of Montgomery County, - free multi-component exercise class specially designed for children ages 6-12. One hour class meets 2x a week includes: tips on healthy lifestyle, evidence-based fun exercise program, nutritious snack. 125 children enrolled in program at five sites.
	Evaluation: Biannual fitness assessments in fall and spring utilize evidence-based President's Challenge Program. In comparing results from June 2009 to December 2008, average scores declined for girls in push up test, curl up test, shuttle run; remained same in sit and reach. average scores for boys declined in push up test, remained same for curl up test, and improved in shuttle run and sit and reach. Plan: use results to increase activity in areas that showed decline.
Program:	**Need: Diabetes Prevention**
	Program: Chronic Disease Management Initiative: Diabetes Prevention and Self-Management Class. Designed to help pre-diabetic make lifestyle changes (weight loss, exercise) to prevent or delay onset of diabetes or cardiovascular disease. Free 12 week classroom program followed by 6 months of telephone support. Blood tests indicating risk are required for inclusion in program.
	Evaluation: Monitoring of class attendance, weight control, exercise regimen, AC1 count, lipid profile; 23 out of 27 completed classes. 86% attended at least 80% of classes; 47% attended 100% of classes; weight loss achieved by 93% of attendees; 47% increased exercise level from pre-program levels; AC1 count improved in 100%; Lipid profile improved in 80-100% of participants

	Johns Hopkins Bayview
Identification of Needs:	**community health assessments, health department statistics, direct community contact, analysis of hospital programs**
Decision Making Process:	**Hospital Board of Trustees, executive and clinical leadership, community relations staff, community advisory boards, Johns Hopkins Hospital, primary care physicians serving immediate community**
Program:	**Need: Cardiovascular disease prevention**
	Program: Food Re-Education for School Health cardiac disease prevention program in the elementary schools.
	Evaluation: Annual evaluation - Pre and post measurement of children's knowledge, Teacher evaluations. Based on results, plan to continue program
Program:	**Need: Cardiovascular disease prevention**
	Program: Community Health Action program - a partnership with the community to promote health, smoke-free families effort in place for several years providing a resouce guide for distribution at the hospital and in the community.
	Evaluaton: Self-assessment by participants; strategic planning. Based on evaluation, focus has been shifted to diabetes and obesity.

Title 10 DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Subtitle 37 HEALTH SERVICES COST REVIEW COMMISSION

10.37.03 Types and Classes of Charges Which Cannot Be Changed Without Prior Commission Approval

Authority: Health-General Article, §§ 19-207, and 19-219, Annotated Code of Maryland

NOTICE OF PROPOSED ACTION

The Health Services Cost Review Commission proposes to amend **Regulation .09** under **COMAR 10.37.03 Types and Classes of Charges Which Cannot Be Changed Without Prior Commission Approval**. This action was considered and approved for promulgation by the Commission at a previously announced open meeting held on June 9, 2010, notice of which was given pursuant to State Government Article, § 10-506(c), Annotated Code of Maryland. If adopted, the proposed amendments will become effective on or about October 4, 2010.

Statement of Purpose

The purpose of this action is to clarify that a Commission-approved rebundled rate applies to a non-physician service provided by a third-party contractor to a hospital inpatient at an unregulated facility off-site of the hospital's campus.

Comparison of Federal Standards

There is no corresponding federal standard to this proposed action.

Estimate of Economic Impact

The proposed action has no economic impact.

Opportunity for Public Comment

Comments may be sent to Diana M. Kemp, Regulations Coordinator, Health Services Cost Review Commission, 4160 Patterson Avenue, Baltimore, Maryland 21215, or call (410)

764-2576, or fax to (410) 358-6217, or email to dkemp@hscrc.state.md.us. The Health Services Cost Review Commission will consider comments on the proposed amendments until August 2, 2010. A hearing may be held at the discretion of the Commission.

.09 Rates for Non-Physician Services Provided to Hospital Inpatients by Third-Party Contractors.

A. A non-physician inpatient service is defined as a hospital service under the jurisdiction of the Commission provided by a third-party contractor to a hospital inpatient [either on or off-site of the hospital] at an unregulated facility off-site of the hospital's campus.

B. - H. Text unchanged.

DONALD A. YOUNG, M.D.
Chairman
Health Services Cost Review Commission

Title 10 **DEPARTMENT OF HEALTH AND MENTAL HYGIENE**

Subtitle 37 **HEALTH SERVICES COST REVIEW COMMISSION**

10.37.10 **Rate Application and Approval Procedures**

Authority: Health-General Article, §§ 19-207, 19-214.1, and 19-214.2
Annotated Code of Maryland

NOTICE OF PROPOSED ACTION

The Health Services Cost Review Commission proposes to amend Regulations **.26A** and **.26A-1**, to adopt new Regulation **.26A-2**, and to amend Regulation **.26B** under **COMAR 10.37.10 Rate App lication an d Ap proval Proce dures**. This action was considered and approved for promulgation by the Commission at a previously announced open meeting held on June 9, 2010, notice of which was given pursuant to State Government Article, § 10-506(c), Annotated Code of Maryland. If adopted, the proposed amendments will become effective on or about October 4, 2010.

Statement of Purpose

The purpose of this action is to alter the requirements for hospital financial assistance and debt collection policies and to make the requirements applicable to chronic care hospitals that are subject to HSCRC rate-setting. These proposed amendments conform to recently enacted legislation (Chapters 60 and 61 of 2010 Laws of Maryland) and to Commission-approved recommendations for providing incentives to hospitals to provide free and reduced-cost care and certain protections to patients without means to pay their hospital bills.

Comparison of Federal Standards

There is no corresponding federal standard to this proposed action.

Estimate of Economic Impact

See Attached.

Opportunity for Public Comment

Comments may be sent to Diana M. Kemp, Regulations Coordinator, Health Services Cost Review Commission, 4160 Patterson Avenue, Baltimore, Maryland 21215, or (410) 764-2576, or fax to (410) 358-6217, or email to dkemp@hscrc.state.md.us. The Health Services Cost Review Commission will consider comments on the proposed amendments until August 2, 2010. A hearing may be held at the discretion of the Commission.

.26 [Differentials.] Patient Rights and Obligations; Hospital Credit and Collection, Financial Assistance Policies.

A. Hospital Information Sheet.

(1)(a) – (c) (i) (text unchanged)

(ii) The patient's rights and obligations with regard to the hospital bill[;], including the patient's rights and obligations with regard to reduced-cost medically necessary care due to a financial hardship;

(iii) – (iv) (text unchanged)

(d) – (e) (text unchanged)

(2) – (4) (text unchanged)

A-1. Hospital Credit and Collection Policies.

(1) (text unchanged)

(2) The policy shall:

[(a) - (b)]

[(c)] (a) - [e] (c) (text unchanged)

[(f)](d) Describe the circumstances in which the hospital will seek a judgment against a patient [.];

(e) Provide for a refund of amounts collected from a patient or the guarantor of a patient who was later found to be eligible for free care on the date of service, in accordance § A-1 (3) of this regulation;

(f) If the hospital, has obtained a judgment against or reported adverse information to a consumer reporting agency about a patient who later was found to be eligible for free care on the date of the service for which the judgment was awarded or the adverse information was reported, require the hospital to seek to vacated the judgment or strike the adverse information; and

(g) Provide a mechanism for a patient to file with the hospital a complaint against the hospital or an outside collection agency used by the hospital regarding the handling of the patient's bill.

(h) Provide detailed procedures for the following actions:

(i) When a patient debt may be reported to a credit reporting agency;

(ii) When legal action may commence regarding a patient debt;

(iii) When garnishments may be applied to a patient's or patient guarantor's income; and

(iv) When a lien on a patient's or patient guarantor's personal residence or motor vehicle may be placed.

(3) Beginning October 1, 2010, as provided by Health-General Article, § 19-214.2(c):

(a) A hospital shall provide for a refund of amounts exceeding $25 collected from a patient or the guarantor of a patient who, within a 2-year period after the date of

service, was found to be eligible for free care on the date of service.

(b) A hospital may reduce the 2-year period under §A-1(3)(a) of this regulation to no less than 30 days after the date the hospital requests information from a patient, or the guarantor of a patient, to determine the patient's eligibility for free care at the time of service, if the hospital documents the lack of cooperation of the patient or the guarantor of a patient in providing the required information.

(c) If a patient is enrolled in a means-tested government health care plan that requires the patient to pay out-of-pocket for hospital service, a hospital shall have a refund policy that complies with the terms of the patient's plan.

(4) For at least 120 days after issuing an initial patient bill, a hospital may not report adverse information about a patient to a consumer reporting agency or commence civil action against a patient for nonpayment unless the hospital documents the lack of cooperation of the patient or the guarantor of the patient in providing information needed to determine the patient's obligation with regard to the hospital bill.

(5) A hospital shall report the fulfillment of a patient's payment obligation within 60 days after the obligation is fulfilled to any consumer reporting agency to which the hospital had reported adverse information about the patient.

(6) A hospital may not force the sale or foreclosure of a patient's primary residence to collect a debt owed on a hospital bill. If a hospital holds a lien on a patient's primary residence, the hospital may maintain its position as a secured creditor with respect to other creditors to whom the patient may owe a debt.

(7) If a hospital delegates collection activity to an outside collection agency, the hospital shall:

(a) Specify the collection activity to be performed by the outside collection agency through an explicit authorization or contract;

(b) Specify procedures the outside collection agency must follow if a patient appears to qualify for financial assistance; and

(c) Require the outside collection agency to:

(i) In accordance with the hospital's policy, provide a mechanism for a patient to file with the hospital a complaint against the hospital or the outside collection agency regarding the handing of patient's bill; and

(ii) If a patient files a complaint with the collection agency, forward the complaint to the hospital.

(8) The Board of Directors of each hospital shall review and approve the financial assistance and debt collection policies of the hospital every two (2) years. A hospital may not alter its financial assistance or debt collection policies without approval by the Board of Directors.

[3](9) The Commission shall review each hospital's implementation of and compliance with the hospital's policies and the requirements of § A-1(2) of this regulation.

A-2. Hospital Financial Assistance Responsibilities.

(1) For purposes of this regulation, the following definitions apply:

(a) "Financial hardship" means medical debt, incurred by a family over a 12-month period that exceeds 25% of family income.

(b) "Medical debt" means out of pocket expenses, excluding copayments, coinsurance, and deductibles, for medical costs billed by a hospital.

(2) Financial Assistance Policy.

(a) On or before June 1, 2009, each hospital and on or before October 1, 2010, each chronic care hospital under the jurisdiction of the Commission shall develop a written financial assistance policy for providing free and reduced-cost care to low-income patients who lack health care coverage or to patients whose health insurance does not pay the full cost of the hospital bill. The financial assistance policy shall provide, at a minimum:

(i) Free medically necessary care to patients with family income at or below 200 percent of the federal poverty level;

(ii) Reduced-cost, medically necessary care to low-income patients with family income between 200 and 300 percent of the federal poverty level, in accordance with the mission and service area of the hospital;

(iii) A maximum patient payment for reduced-cost care not to exceed the charges minus the hospital mark-up;

(iv) A payment plan available to uninsured patients with family income between 200 and 500 percent of the federal poverty level who request assistance; and

(v) A mechanism for a patient to request the hospital to reconsider the denial of free or reduced care.

(b) A hospital whose financial assistance policy as of May 8, 2009 provides for free or reduced-cost medical care to patients at income threshold higher than those set forth above, may not reduce that income threshold.

(c) Presumptive Eligibility for Free Care. Unless otherwise eligible for Medicaid or CHIP, patients who are beneficiaries/ recipients of the following means-tested social services programs are deemed eligible for free care, provided that the patient submits proof of enrollment within 30 days unless the patient or the patient's representative requests an additional 30 days:

(i) Households with children in the free or reduced lunch program;

(ii) Supplemental Nutritional Assistance Program (SNAP);

(iii) Low-income-household energy assistance program;

(iv) Primary Adult Care Program (PAC) (until such time as inpatient benefits are added to the PAC benefit package; or

(v) Women, Infants and Children (WIC).

(d) A hospital that believes that an increase to the income thresholds as set forth above may result in undue financial hardship to it, may file a written request with the Commission that it be exempted from the increased threshold. In evaluating the hospital's request for exemption, the Commission shall consider the hospital's:

(i) Patient mix;

(ii) Financial condition;

(iii) Level of bad debt experienced;

(iv) Amount of charity care provided; and

(v) Other relevant factors.

(e) Based on staff's evaluation of the written request for an exemption, the Executive Director shall respond in writing within a reasonable period of time approving or disapproving the hospital's exemption request.

(f) A hospital denied an exemption request shall be afforded an opportunity to address the Commission at a public meeting on its request. Based on arguments made at the public meeting, the Commission may approve, disapprove, or modify the Executive Director's decision on the exemption request.

(3) Financial Hardship Policy.

(a) Subject to §A-2(3)(b) and (c) of this regulation, the financial assistance policy required under this regulation shall provide reduced-cost medically necessary care to patients with family income below 500% of the federal poverty level who have a financial hardship.

(b) A hospital may seek and the Commission may approve a family income threshold that is different than the family income threshold under §A-2(C)(1) of this regulation.

(c) In evaluating a hospital's request to establish a different family income threshold, the Commission shall take into account:

(i) The median family income in the hospital's service area;

(ii) The patient mix of the hospital;

(iii) The financial condition of the hospital;

(iv) The level of bad debt experienced by the hospital;

(v) The amount of the charity care provided by the hospital; and

(vi) Other relevant factors.

(d) If a patient has received reduced-cost medically necessary care due to a financial hardship, the patient or any immediate family member of the patient living in the same household:

(i) Shall remain eligible for reduced-cost medically necessary care when seeking subsequent care at the same hospital during the 12-month period beginning on the date on which the reduced-cost medically necessary care was initially received; and

(ii) To avoid an unnecessary duplication of the hospital's determination of eligibility for free and reduced-cost care, shall inform the hospital of the patient's or family member's eligibility for the reduced-cost medically necessary care.

(4) If a patient is eligible for reduced-cost medical care under a hospital's financial assistance policy or financial hardship policy, the hospital shall apply the reduction in charges that is most favorable to the patient.

(5) A notice shall be posted in conspicuous places throughout the hospital including the billing office informing patients of their right to apply for financial assistance and who to contact at the hospital for additional information.

(6) Each hospital shall use a Uniform Financial Assistance Application in the manner prescribed by the Commission in order to determine eligibility for free and reduced-cost care.

(7) Each hospital shall establish a mechanism to provide the Uniform Financial Assistance Application to patients who do not indicate public or private health care coverage. A hospital may require from patients or their guardians only those documents required to validate the information provided on the Application.

(8) Asset Test Requirements. A hospital may, in its discretion, consider household monetary assets in determining eligibility for financial assistance in addition to the income-based criteria, or it may choose to use only income-based criteria. If a hospital chooses to utilize an asset test, that test must adhere to the following types of assets:

(a) "Monetary assets" are those assets that are convertible to cash excluding $150,000 in a primary residence, and retirement assets, which are defined to be those assets where the Internal Revenue Service has granted preferential tax treatment as a retirement account including, but not limited to, deferred-compensation plans qualified under the Internal Revenue Code, or nonqualified deferred-compensation plans.

(b) A principal residence may be considered in making a financial assistance determination after first excluding a "safe harbor" equity in the home in the amount of $150,000.

(c) At a minimum, the first $10,000 of monetary assets may not be considered when determining eligibility for free or reduced cost care.

.26B. Working Capital Differentials--Payment of Charges.

(1)- (3) (text unchanged)

(4) Hospital Billing Responsibilities.

(a)- (c) (text unchanged)

[**(5) (a) - (g)**]

(5) Hospital Written Estimate.

(a) On request of a patient made before or during treatment, a hospital shall provide to the patient a written estimate of the total charges for the hospital services, procedures, and supplies that reasonably are expected to be provided and billed to the patient by the hospital.

(b) The written estimate shall state clearly that it is only an estimate and actual charges could vary.

(c) A hospital may restrict the availability of a written estimate to normal business office hours.

(d) The provisions set forth in §B(5)(a)-(c) of this regulation do not apply to emergency services.

C. (text unchanged)

DONALD A. YOUNG, M.D.
Chairman
Health Services Cost Review Commission

IMPACT STATEMENT

PART A
(check one option)

ESTIMATE OF ECONOMIC IMPACT

_______ The proposed action has no economic impact.

OR

__X__ The proposed action has an economic impact.

I. Summary of Economic Impact. Implementation of the action proposed will expand the provision of hospital care to patients, protect their rights, and identify their obligations with regard to reduced-cost medically necessary care due to a financial hardship.

II. Types of Economic Impacts.	Revenue (R+/R-) Expenditure (E+/E-)	Magnitude
A. On issuing agency:	N/A	
B. On other State agencies:	N/A	
C. On local governments:	N/A	

	Benefit (+) Cost (-)	Magnitude
D. On regulated industries or trade groups:	(+/-)	None

Assumptions are based on the recognition that hospitals will be required to provide free or reduced-cost care to a greater range of patients; hospitals also will now be compelled to handle patient bills differently and in a way most favorable to patients. However, the rate setting system does allow for a hospital's reasonable provision of uncompensated care to be included in hospital rates.

E. On other industries or trade groups:	(-)	Minimal

Assumptions are based on the recognition that payers ultimately pay for the expansion of uncompensated care. However, because this expansion is largely a shift from bad debt to charity care, any added payments for payers will be minimal.

F.	Direct and indirect effects on public:	(+)	Substantial

Assumptions are based on the proposed action's intention of protecting a patient's rights vis-a-vis hospital credit and collection policies; identifying a patient's obligations with regard to reduced-cost medically necessary care due to financial hardship; allowing a patient to obtain a written estimate of total charges; protecting the patient from a hospital's attempt to force the sale or foreclosure of a patient's primary residence to collect an outstanding debt; providing for a refund of amounts collected from a patient later found to have been eligible for free care; providing some protection to a patient regarding the handling of the patient's bill; requiring an outside collection agency contracted for by a hospital to abide by the hospital's credit and collection policy; providing for a maximum patient payment for reduced-cost care; a payment plan to certain uninsured patients; providing a mechanism for a patient to request a hospital's reconsideration of a hospital's denial of free or reduced care; and providing a mechanism in the hospital's credit and collection policy for a patient to file a complaint regarding how the patient's bill has been handled.

III. Assumptions. (Identified by Impact Letter and Number from Section II.)

PART B

(Check one option)

Economic Impact on Small Businesses

__X__ The proposed action has minimal or no economic impact on small businesses.

or

______ The proposed action has an economic impact on small businesses.
See Estimate of Economic Impact.

Impact on Individuals with Disabilities

(Check one option)

__X__ The proposed action has minimal impact on individuals with disabilities.

or

______ The proposed action has an impact on individuals with disabilities.
See Estimate of Economic Impact.

Opportunity for Public Comment

PART C

(For legislative use only; not for publication)

A. Fiscal Year in which regulations will become effective: FY 2011.

B. Does the budget for fiscal year in which regulations become effective contain funds to implement the regulations: N/A

___ YES ___ NO

C. If "yes", state whether general, special (exact name), or federal funds will be used:

D. If "no", identify the source(s) of funds necessary for implementation of these regulations:

E. If these regulations have no economic impact under Part A., indicate reason briefly:

F. If these regulations have minimal or no economic impact on small businesses under Part B, indicate the reason. These regulations do not target small businesses, but rather the healthcare environment generally.