STATE of MARYLAND
DEPARTMENT of HEALTH and MENTAL HYGIENE

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479th MEETING OF THE HEALTH SERVICES COST REVIEW COMMISSION
July 6, 2011

PUBLIC SESSION OF THE
HEALTH SERVICES COST REVIEW COMMISSION
10:00 a.m.

1. **Review of the Public Meeting Minutes of June 1, 2011**

2. **Executive Director's Report**

3. **Docket Status – Cases Closed**
   2110N – Western Maryland Health System
   2112N – University Specialty Hospital
   2113A – University of Maryland Medical Center
   2115A – Holy Cross Hospital
   2117A – Johns Hopkins Health System

4. **Docket Status – Cases Open**
   2114N – Adventist Behavioral Health
   2116N – Germantown Emergency Center
   2118N – Bowie Emergency Center
   2119R – Carroll County Hospital
   2120R – Dimensions Healthcare System
   2121A – Johns Hopkins Health System
   2122A – Johns Hopkins Health System
   2123A – Johns Hopkins Health System
   2124A – Johns Hopkins Health System
   2125A – Johns Hopkins Health System

5. **Final Recommendations on Quality Based Reimbursement Methodology for FY 2012 Scaling**

6. **Final Recommendation on the FY 2012 Reasonableness of Charges (ROC) Methodology and Scaling for the ROC, QBR, and MHACs**

   a.) **Maryland Hospital Association's Presentation**

   b.) **Johns Hopkins Hospital's Presentation**

7. **Report on Results of Uncompensated Care Policy and Final Recommendation to Modify Charity Care Adjustment**

8. **FY 2010 Community Benefit Report and Changes to Reporting Requirements for the FY 2011 Community Benefit Report and Narrative**

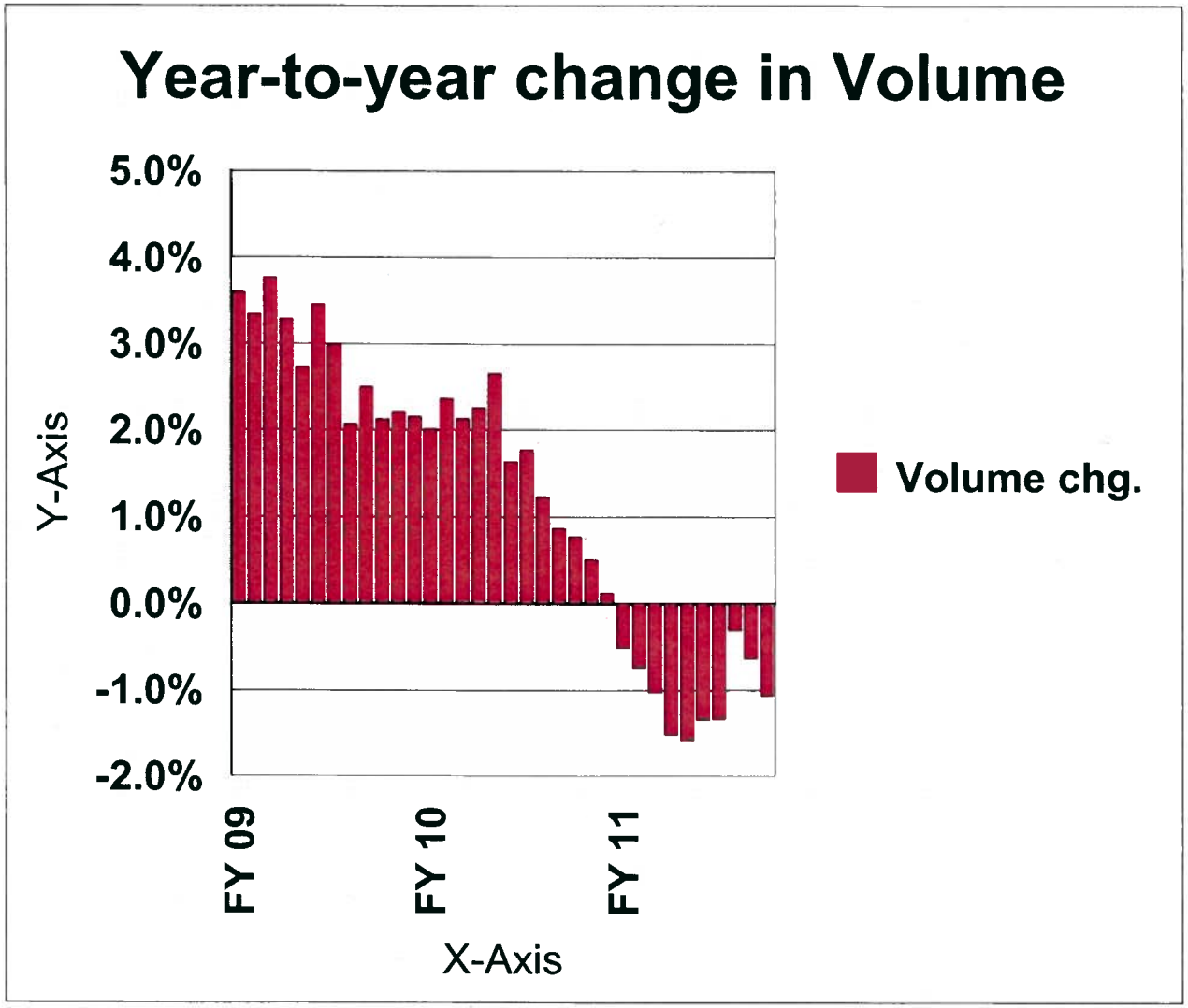
9. **Hearing and Meeting Schedule**

Executive Director's Report

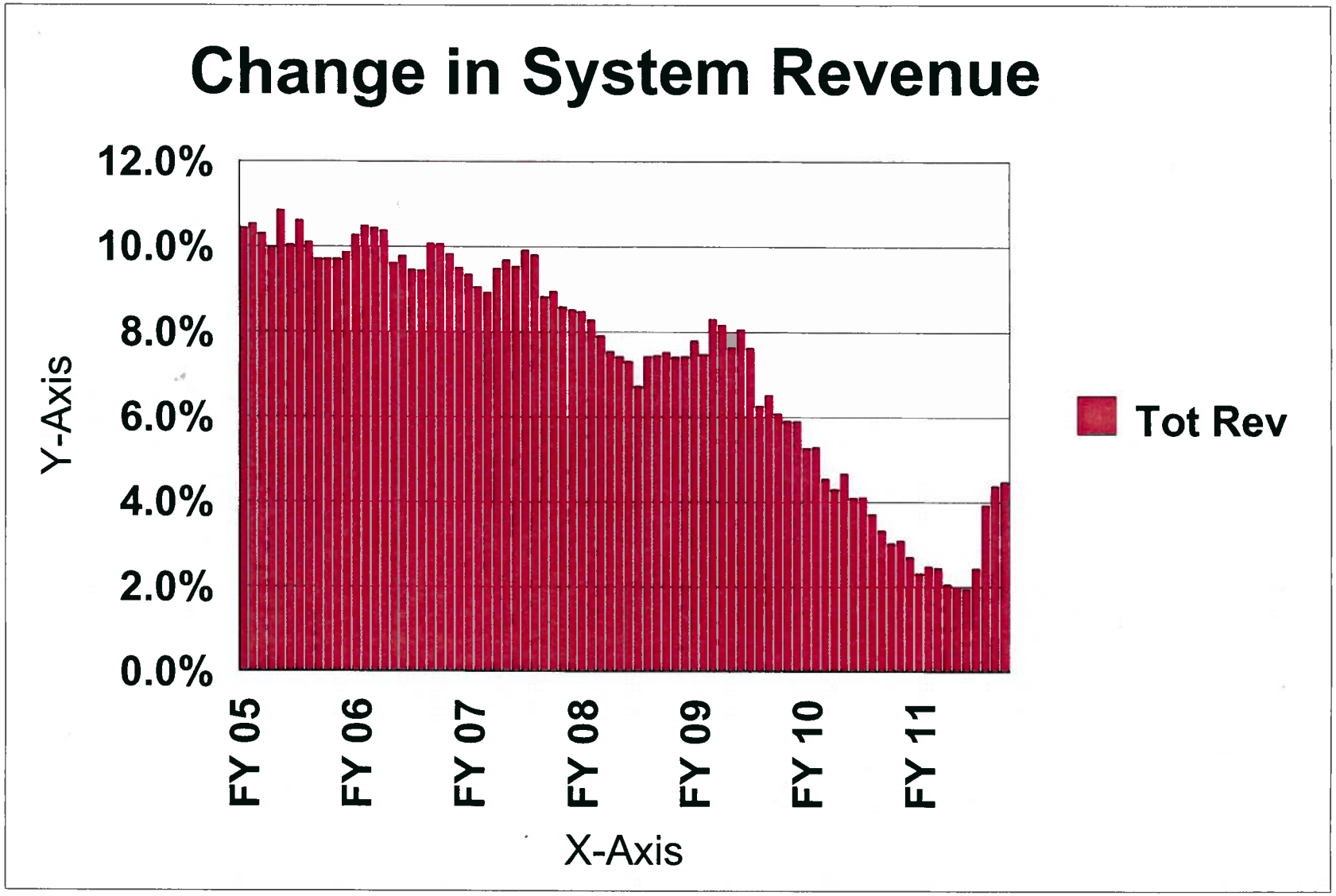
July 6, 2011

Current and Future Projects	Status/Timing
1) Quality-Based Reimbursement (QBR) - Related to HSCRC plan to request an exemption/certification from Secretary of HHS that QBR "meets or exceeds" CMS requirements	July/August
2) Reasonableness of Charges (ROC) for FY 2012 - Work through some issues for FY 12 ROC - Resident and Intern Survey/Residual Outlier - Also discuss impact of TPR/ARR and other fixed Payment structures on the ROC	August – Sept
3) Scaling of Quality Measures - Preparation of recommendation for prospective scaling Of QBR and MHCAs	August
4) Admission-Readmission Rate pilots (ARR) - 19 hospitals close to finalizing ARR agreements - Additional 8 expressed interest - Base year and measurement year (June 1 to June 30)	July
5) Total Patient Revenue (TPR) Agreements and negotiations - Discussions with hospitals about TPR	July
6) Review of System Performance	
7) Maryland Waiver modification request	July - October
8) Personnel	

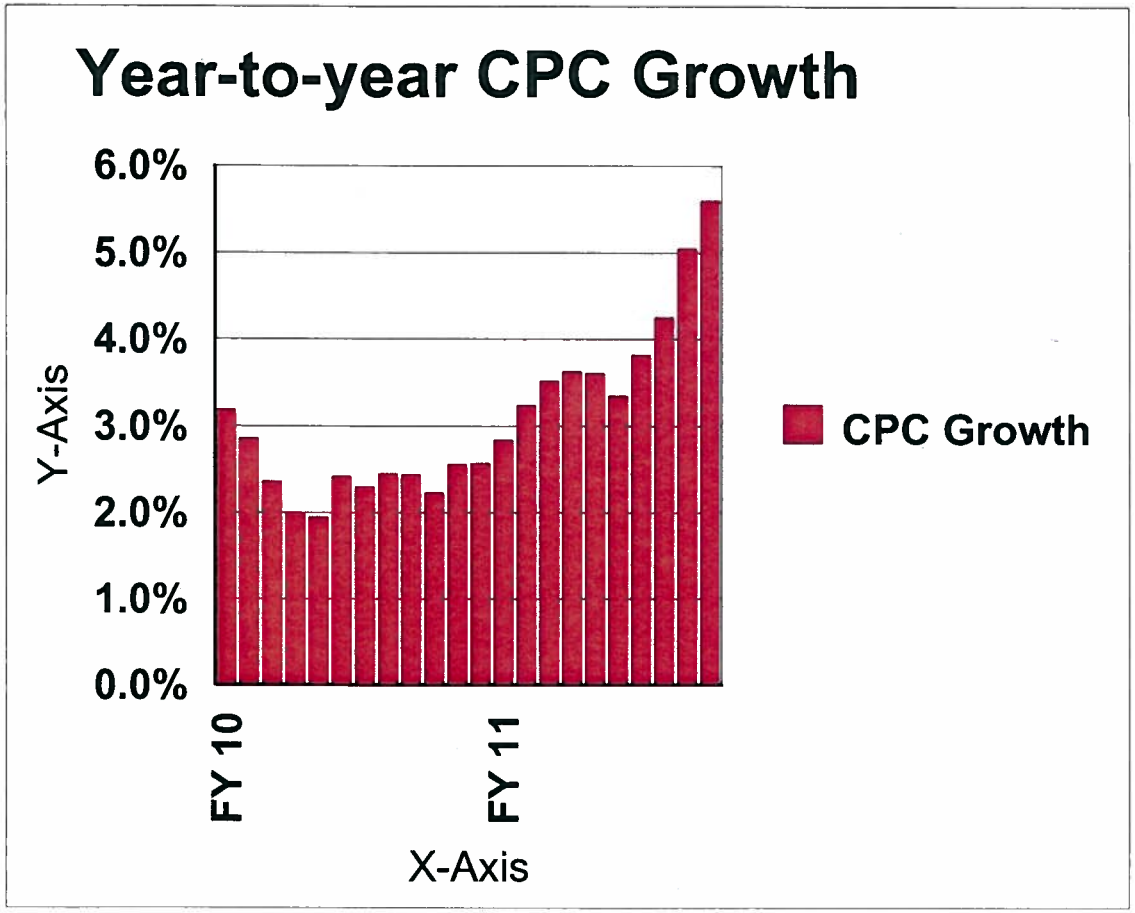
FY 09	3.60%
	3.34%
	3.77%
	3.29%
	2.73%
	3.45%
	2.99%
	2.07%
	2.50%
	2.12%
	2.20%
	2.16%
FY 10	2.01%
	2.36%
	2.13%
	2.26%
	2.66%
	1.63%
	1.77%
	1.23%
	0.87%
	0.77%
	0.51%
	0.12%
FY 11	-0.51%
	-0.74%
	-1.04%
	-1.52%
	-1.59%
	-1.35%
	-1.34%
	-0.32%
	-0.64%
	-1.07%



FY 08	8.49%
	8.29%
	7.91%
	7.55%
	7.42%
	7.31%
	6.72%
	7.43%
	7.45%
	7.53%
	7.41%
	7.43%
FY 09	7.79%
	7.48%
	8.31%
	8.18%
	7.64%
	8.07%
	7.63%
	6.27%
	6.52%
	6.09%
	5.91%
	5.90%
FY 10	5.27%
	5.29%
	4.54%
	4.30%
	4.67%
	4.09%
	4.11%
	3.71%
	3.33%
	3.02%
	3.09%
	2.70%
FY 11	2.32%
	2.48%
	2.44%
	2.05%
	1.97%
	1.96%
	2.43%
	3.92%
	4.37%
	4.47%



FY 10	3.19%
	2.86%
	2.36%
	2.00%
	1.95%
	2.42%
	2.30%
	2.45%
	2.44%
	2.23%
	2.56%
	2.57%
FY 11	2.84%
	3.24%
	3.52%
	3.63%
	3.61%
	3.35%
	3.82%
	4.25%
	5.05%
	5.60%



IN RE: THE PARTIAL RATE	*****	**BEFORE THE HEALTH SERVICES**
APPLICATION OF THE	*****	**COST REVIEW COMMISSION**
CARROLL HOSPITAL	*****	**DOCKET: 2011**
CENTER	*****	**FOLIO: 1929**
WESTMINSTER, MARYLAND	*****	**PROCEEDING: 2119R**

Staff Recommendation

July 6, 2011

This recommendation was approved by the Commission at the July 6, 2011 public meeting.

Introduction

On May 31, 2011, Carroll Hospital Center (the "Hospital") submitted a partial rate application to the Commission for a rate for Radiation Therapy (RAT) services to be provided to both inpatients and outpatients. This new rate would replace its currently approved rebundled RAT rate. A rebundled rate is approved by the Commission when a hospital provides certain non-physician services to inpatients through a third-party contractor off-site. By approving a rebundled rate, the Commission makes it possible for a hospital to bill for services provided off site, as required by Medicare. In this case, however, as of July 1, 2011, the Hospital will be providing RAT services on-site to both inpatients and outpatients. The Hospital requests that the RAT rate be set at the state-wide median rate and be effective July 1, 2011.

Staff Evaluation

To determine if the Hospital's RAT rate should be set at the statewide median or at a rate based on its own cost experience, the staff requested that the Hospital submit to the Commission its RAT cost and statistical data projections for FY 2012. Based on information received, it was determined that the RAT rate based on the Hospital's projected data would be $28.34 per RVU, while the statewide median rate for RAT services is $26.12 per RVU.

Recommendation

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

1. That COMAR 10.37.10.07 requiring that rate applications be filed 60 days before the opening of a new service be waived;
2. That an RAT rate of $26.12 per RVU be approved effective July 1, 2011;
3. That the RAT rate not be rate realigned until a full year's cost experience data have been reported to the Commission; and
4. That incremental regulated revenue will be added to the Hospital's TPR with the final amount to be negotiated with HSCRC staff in conjunction with the regulation of the Hospoital's entire radiation and medical oncology practice.

IN RE: THE PARTIAL RATE	*	**BEFORE THE HEALTH SERVICES**
APPLICATION OF	*	**COST REVIEW COMMISSION**
DIMENSIONS	*	**DOCKET: 2011**
HEALTHCARE SYSTEM	*	**FOLIO: 1930**
LAUREL, MARYLAND	*	**PROCEEDING: 2120R**

* *

<u>Staff Recommendation</u>

July 6, 2011

Introduction

On May 31, 2011, Dimensions Healthcare System, on behalf of its member hospitals Prince George's Hospital Center (PGHC) and Laurel Regional Hospital (LRH), submitted a request to the Commission for approval for a Chronic Care (CHR) rate for LRH. The new rate is necessary because on June 30, 2011, the patients in PGHC's CHR unit will be moved to LRH. Dimensions Healthcare System has received approval from the Maryland Health Care Commission for licensure of these CHR beds at LRH. LRH has requested that effective July I, 2011, the Commission approve PGHC's currently approved CHR rate for LRH, increased by the FY 2012 core update factor of 1.56%.

Recommendation

After review of the System's application, staff recommends:

1) That LRH's new CHR rate be based on PGHC's approved CHR rate;
2) That to ensure revenue neutrality, LRH's mark-up of 1.175109 be substituted for PGHC's mark-up of 1.213134, reducing the rate from $698.9463 to $677.0382;
3) That core inflation of 1.56% be added to the rate, increasing the CHR rate to $687.6000;
4) That a CHR rate of $687.6000 be approved for LRG effective July 1, 2011;
5) That because these cases are excluded from the Charge-per-Case standard , there should be no change to LRH's or PGHC's Charge-per-Case standard; and
6) That the CHR rate not be rate realigned until a full year's experience data have been reported to the Commission.

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION	*	**COMMISSION**	
JOHNS HOPKINS HEALTH	*	**DOCKET:**	**2011**
SYSTEM	*	**FOLIO:**	**1931**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2121A**

Staff Recommendation

July 6, 2011

This recommendation was approved by the Commission at the July 6, 2011 public meeting.

I. INTRODUCTION

On June 7, 2011, Johns Hopkins Health System ("System") filed a renewal application on behalf of its member hospitals, Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, and Howard County General Hospital (the "Hospitals") requesting approval from the HSCRC to continue to participate in a global rate arrangement for cardiovascular procedures and to add global rates for kidney transplant services with the Canadian Medical Network to the arrangement. The Hospitals request that the Commission approve the arrangement for one year beginning July 1, 2011.

II. OVERVIEW OF APPLICATION

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

III. FEE DEVELOPMENT

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

IV. IDENTIFICATION AND ASSESSMENT OF RISK

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

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

V. STAFF EVALUATION

Staff finds that the actual experience for cardiovascular services under the arrangement for the last year has been favorable. After reviewing the hospital portion of the new global rates for kidney transplant services, staff found that they were based on hospital experience data utilized to develop global rates for other successful kidney transplant arrangements.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission: 1) waive the requirement that alternative rate applications be filed 30 days before the proposed effective date; 2) approve the Hospitals' application for an alternative method of rate determination for cardiovascular procedures and kidney transplant services for one year beginning July 1, 2011. The Hospitals must file a renewal application annually for continued participation.

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

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION	*	**COMMISSION**	
JOHNS HOPKINS HEALTH	*	**DOCKET:**	**2011**
SYSTEM	*	**FOLIO:**	**1932**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2122A**

Staff Recommendation

July 6, 2011

This recommendation was approved by the Commission at the July 6, 2011 public meeting.

I. INTRODUCTION

Johns Hopkins Health System (“System”) filed an application with the HSCRC on June 7, 2011 on behalf of Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center (the “Hospitals”) for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System requests approval from the HSCRC for participation in a global rate arrangement for kidney transplant, bone marrow transplant, and cardiovascular services with Active Care Management for a period of one year beginning July 1, 2011.

II. OVERVIEW OF APPLICATION

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

III. FEE DEVELOPMENT

The hospital portion of the new global rates was developed by calculating mean historical charges for patients receiving kidney, bone marrow transplants, and cardiovascular services at the Hospitals. The remainder of the global rate is comprised of physician service costs. Additional per diem payments were calculated for cases that exceed a specific length of stay outlier threshold.

IV. IDENTIFICATION AND ASSESSMENT OF RISK

The Hospitals will submit bills to JHHC for all contracted and covered services. JHHC is responsible for billing the payer, collecting payments, disbursing payments to the Hospitals at their full HSCRC approved rates, and reimbursing the physicians. The System contends that the arrangement among JHHC, the Hospitals, and the physicians

holds the Hospitals harmless from any shortfalls in payment from the global price contract. JHHC maintains it has been active in similar types of fixed fee contracts for several years, and that JHHC is adequately capitalized to bear the risk of potential losses.

V. STAFF EVALUATION

Since the format utilized to calculate the case rate, i.e., historical data for like cases, has been utilized as the basis for other successful transplant and cardiovascular arrangements in which the Hospitals are currently participating, staff believes that the Hospitals can achieve a favorable experience under this arrangement.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission: 1) waive the requirement that alternative applications be filed 30 days before the proposed effective date; 2) approve the Hospitals' application for an alternative method of rate determination for kidney, bone marrow transplant, and cardiovascular services for a one year period commencing July 1, 2011. The Hospitals will need to file a renewal application for review to be considered for continued participation. Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospitals for the approved contract. This document would formalize the understanding between the Commission and the Hospitals, and would include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION	*	**COMMISSION**	
JOHNS HOPKINS HEALTH	*	**DOCKET:**	**2011**
SYSTEM	*	**FOLIO:**	**1933**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2123A**

Staff Recommendation

July 6, 2011

This recommendation was approved by the Commission at the July 6, 2011 public meeting.

I. INTRODUCTION

Johns Hopkins Health System (“System”) filed an application with the HSCRC on June 7, 2011 on behalf of Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center (the “Hospitals”) for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System requests approval from the HSCRC for participation in a global rate arrangement for solid organ and bone marrow transplant services with MultiPlan, Inc. for a period of three years beginning July 1, 2011.

II. OVERVIEW OF APPLICATION

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

III. FEE DEVELOPMENT

The hospital portion of the new global rates was developed by calculating mean historical charges for patients receiving solid organ and bone marrow transplant services at the Hospitals. The remainder of the global rate is comprised of physician service costs. Additional per diem payments were calculated for cases that exceed a specific length of stay outlier threshold.

IV. IDENTIFICATION AND ASSESSMENT OF RISK

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

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

V. STAFF EVALUATION

Since the format utilized to calculate the case rate, i.e., historical data for like cases, has been utilized as the basis for other successful transplant arrangements in which the Hospitals are currently participating, staff believes that the Hospitals can achieve a favorable experience under this arrangement.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission: 1) waive the requirement that alternative applications be filed 30 days before the proposed effective date; 2) approve the Hospitals' application for an alternative method of rate determination for solid organ and bone marrow transplant services, for a one year period commencing July 1, 2011. The Hospitals will need to file a renewal application for review to be considered for continued participation. Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospitals for the approved contract. This document would formalize the understanding between the Commission and the Hospitals, and would include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION	*	**COMMISSION**	
JOHNS HOPKINS HEALTH	*	**DOCKET:**	**2011**
SYSTEM	*	**FOLIO:**	**1935**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2125A**

Staff Recommendation

July 6, 2011

This recommendation was approved by the Commission at the July 6, 2011 public meeting.

I. INTRODUCTION

Johns Hopkins Health System (“System”) filed an application with the HSCRC on June 24, 2011 on behalf of Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center (the “Hospitals”) for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System requests approval from the HSCRC to continue to participate in a global rate arrangement for live donor kidney transplant services with National Health Services, Inc. for a period of one year beginning August 1, 2011.

II. OVERVIEW OF APPLICATION

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

III. FEE DEVELOPMENT

The hospital portion of the new global rates was developed by calculating mean historical charges for patients receiving live donor kidney transplants at the Hospitals. The remainder of the global rate is comprised of physician service costs. Additional per diem payments were calculated for cases that exceed a specific length of stay outlier threshold.

IV. IDENTIFICATION AND ASSESSMENT OF RISK

The Hospitals will continue to submit bills to JHHC for all contracted and covered services. JHHC is responsible for billing the payer, collecting payments, disbursing payments to the Hospitals at their full HSCRC approved rates, and reimbursing the

physicians. The System contends that the arrangement among JHHC, the Hospitals, and the physicians holds the Hospitals harmless from any shortfalls in payment from the global price contract. JHHC maintains it has been active in similar types of fixed fee contracts for several years, and that JHHC is adequately capitalized to bear the risk of potential losses.

V. STAFF EVALUATION

Although there has been no activity since this arrangement was approved at the September 1, 2010 public meeting, staff continues to believe that the Hospitals can achieve favorable performance under this arrangement.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for live donor kidney transplant services, for a one year period commencing August 1, 2011. The Hospitals will need to file a renewal application for review to be considered for continued participation. Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospitals for the approved contract. This document would formalize the understanding between the Commission and the Hospitals, and would include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.

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To: HSCRC Commissioners

From: Dianne Feeney

Re: Modifications to the Draft Recommendation for Updating the Quality Based Reimbursement (QBR) Initiative for FY 2012

Date: June 29, 2011

This is to advise the Commissioners of the most recent changes to the QBR 2012 Update Final Recommendations document. Please note the following changes:

- Children's Asthma Care measures- a note is inserted that it was previously anticipated that data collection would begin in 2009 but data collection for the base year began in CY 2010 so the measures will not be included in QBR until FY 2013 (page 3).
- June 29 QBR Expansion Work Group data review and discussion- a summary of the data modeling and discussion is added to the document. In addition, a table comparing the CMS VBP model and definitions with the QBR program is added (pages 9 & 10).
- Recommendations- Based on the Work Group data review and discussion, staff modified its recommendations to include aligning the QBR model and definitions with the CMS VBP program where it is possible and added a recommendation that staff should propose changes to the QBR recommendations to the Commission that are materially important based on any input we would receive from CMS in the near term (pages 10 & 11).

FINAL RECOMMENDATION REGARDING UPDATING THE QUALITY-BASED REIMBURSEMENT INITIATIVE FOR FY 2012

Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215
(410) 764-2605
Fax (410) 358-6217

June 29, 2011

This final staff recommendation was approved by the Commission at the July 6, 2011 public meeting.

1. Background

The Maryland Health Services Cost Review Commission, at its June 4, 2008 meeting, approved the staff recommendation titled, "Final Staff Recommendations regarding the HSCRC's Quality-Based Reimbursement (QBR) Project - based on deliberations of the Initiation Work Group (IWG)." The QBR Initiative's development and implementation are based upon the deliberations and analysis performed by the HSCRC staff, the Initiation Work Group (IWG), the Evaluation Work Group (EWG), and Commission consultants over the past several years. The IWG completed its work in June 2008 and the EWG was then established to: provide a system for developing new measures, retiring old measures, and recommending other adjustments to the data and scoring; ensure that the QBR Initiative was meeting its established goals; and to support and increase the rationale for linking hospital performance to payment.

2. QBR Initiative Initial Year Implementation

For the first year of the QBR Initiative, the approved recommendations included using data for 19 process measures in four care domains including heart attack, heart failure, pneumonia and surgical care. For these measures, the additional approved recommendations included:

- incorporating new definitions for these core measures as they become available from CMS and the Joint Commission;
- weighting the scores for each process measure equally;
- establishing one index for the process measures for purposes of scoring, anticipating that reporting will be on performance for each domain separately;
- utilizing the Opportunity Model for scoring purposes, whereby a hospital receives credit for each time the measure is performed, and the hospital's available points will be 10 times the number of quality measures;
- utilizing calendar year 2007 as the Base Period and calendar year 2008 as the Measurement Period, establishing the scale for calibrating performance based on the prior year's experience so that thresholds and benchmarks are known in advance;
- counting (for purposes of scoring) the "higher of" either Attainment or Improvement points on each process measure for each hospital – on a 10 point scale for each measure;
- establishing the threshold for Attainment at the 50th percentile, the benchmark at 95th percentile for the non-topped off measures, and for topped off measures, 65 percent and 90 percent respectively;
- applying rewards and incentive payments maintaining revenue neutrality in FY 2010 as part of the FY 2010 Update Factor for individual hospitals;
- determining the amount of funding "at-risk" based on further deliberations and recommendations of the Payment Work Group comprising HSCRC staff and the hospital and payer industries, and based on approval of the Commission;
- scaling reward and incentive payments on a continuous basis for hospitals reporting on a minimum of 5 measures;
- utilizing an exchange rate function (cubed-root functional form) for translating scoring into rewards/incentives without high or low restrictions on eligibility or rewards/incentives achieved;

- establishing a rule to adjust for "down and up" year to year performance on any individual process measure, establishing the base-line for improvement as that hospital's best previous score on that measure;
- establishing a mechanism where the Commission can obtain necessary data directly from hospitals through its own vendor arrangement based on work with the Maryland Health Care Commission in implementing a contract with a data vendor to collect quality data for both MHCC's quality performance guide and the HSCRC QBR Initiative;
- moving over time toward use of complete data and away from sampling;
- assuring public accountability by providing accessibility to data given necessary restrictions on confidentiality;
- carefully planning and managing the public release of quality-related scoring information; and,
- investigating the feasibility in future years of incorporating additional funding ("new money") into the system if Maryland as a state can achieve certain benchmarks vs. the performance of hospitals nationally on the selected performance measures.

Hospital rate adjustments were made for FY 2010 within the parameters of the recommendations specified above. The amount of funding "at risk" for the first year was 0.5 percent consistent with the deliberations and approved recommendations of staff and the Payment Work Group, however, the distribution of payment differential was quite narrow at 0.16 percent as the cube root exchange function was used to translate performance into rewards and penalties. The hospital quality data vendor has been procured by MHCC, and began collecting patient-level quality data in the first quarter of CY 2009. The EWG met regularly to deliberate: measure additions, changes, and deletions; changes to the benchmark and threshold values for topped off measures; and the use of a blended Appropriateness and Opportunity Model for the process measures in order to raise the bar of performance and better distinguish hospital performance in light of the increasing number of topped off measures. The EWG concluded its work in May 2009 with the Commission's approval of the updated QBR recommendations for FY 2011.

3. Approved Changes to the QBR Initiative Beginning FY 2011

New Process Measures- New measures were added consistent with MHCC's timeframe for adding these measures to the Hospital Performance Evaluation Guide:

- AMI 8- Percutaneous Coronary Intervention Timing for AMI patients– base CY 2008, measurement CY 2009, and rate year FY 2011
- SCIP VTE 1- Surgery Patients with Recommended Venous Thromboembolism Prophylaxis Ordered - base CY 2009, measurement CY 2010, and rate year FY 2012
- SCIP VTE 2 - Surgery Patients with Recommended Venous Thromboembolism Prophylaxis Given 24 hours prior and after surgery–base CY 2009, measurement CY 2010, and rate year FY 2012

- SCIP CARD-2 Surgery Patients on Beta-Blocker Therapy Prior to Admission Who Received a Beta-Blocker During the Perioperative Period – base CY 2009, measurement CY 2010, and rate year FY 2012
- SCIP Inf – 4- Cardiac Surgery Patients with Controlled 6 A.M. Postoperative Serum Glucose - base CY 2009, measurement CY 2010, and rate year FY 2012
- SCIP Inf 6- Surgery Patients with Appropriate Hair Removal - base CY 2009, measurement CY 2010, and rate year FY 2012
- Children's Asthma Care Asthma Measures (CAC-1-3)- the base year now is CY 2010, measurement is CY 2011, and adjustments based on performance will be applied to rate year FY 2013); these measure include:
  - CAC 1-Relievers for Inpatient Asthma Systemic
  - CAC 2- Corticosteroids for Inpatient Asthma
  - CAC 3- Home Management Plan of Care (HMPC) Document Given to Patient/Caregiver

(Note: the CAC measures were to be collected beginning with CY 2009 but there was a year delay in their implementation)

Blended Opportunity and Appropriateness Scores-To mitigate the effects of topped off measures better distinguishing hospital performance, and to raise the performance bar, a hybrid of the Opportunity and Appropriateness model was used where hospital scores are based 25% on Opportunity and 75% on Appropriateness for base CY 2008, measurement CY 2009, and rate year FY 2011.

Topped off Measures Benchmarks – Based on analysis of the data in early 2009, the benchmark for topped off measures was changed from 0.9 percent to 0.95 percent to mitigate effects of topped off measures and better distinguish performance.

Maryland Hospital Performance Changes on Measures used for FY 2010 and FY 2011 – For FY 2011 we have 17 measures, compared to 19 measures the previous year. Two measures excluded for this year were:

- AMI-6 Beta Blocker prescribed at arrival (Retired)
- PN3a Blood cultures performed within 24 hours prior to or 24 hours after hospital arrival (No longer required by CMS or MHCC)

Staff compared the average percentage of patients who received each process measure and observed some improvement between 2008 and 2009 CY performance periods as follows:

- 14 measures improved with an average of 1.08 percentage point increase
- 2 measures worsened by less than one percentage point.
- 1 measure- influenza- changed the collection period.

Appendix A contains a list of the 17 measures and their changes from CY 2008 to 2009.

Patient Experience of Care – Based upon the results of analysis of patient experience of care measures data (Hospital Consumer Assessment of Healthcare Providers and Systems – "HCAHPS") relative to other domains of quality measures, and upon proposed modeling of incorporating the patient experience domain in the QBR formula, the Commission approved allowing the option of including this domain for base CY 2009, measurement CY 2010, and rate year FY 2012.

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

The Patient Protection and Affordable Care Act of 2010 requires CMS to fund the aggregate Hospital VBP incentive payments by reducing the base operating diagnosis-related group (DRG) payment amounts that determine the Medicare payment for each hospital inpatient discharge. The law sets the reduction at 1 percent in FY 2013, rising to 2 percent by FY 2017. CMS issued its VBP final rule in April 2011, the details of which are summarized below.

Hospital VBP Measures- For the federal FY 2013 (which begins on October 1, 2012) Hospital VBP program, CMS will measure hospital performance using two domains: the clinical process of care domain, which is comprised of 12 clinical process of care measures, decreased from 17 in the proposed rule, and the patient experience of care domain, which is comprised of the HCAHPS survey measure. The FY 2013 measures are in Appendix B. CMS will add the following measures in the Hospital VBP program for the FY 2014 payment determination: three mortality outcome measures, eight Hospital Acquired Condition (HAC) measures, and two Agency for Healthcare Research and Quality (AHRQ) composite measures. These measures are also specified in Appendix B.

Performance Period- CMS has established a base period that runs from July 1, 2009 through March 1, 2010, and a performance period that runs from July 1, 2011 through March 31, 2012, for the FY 2013 Hospital VBP payment determination. CMS anticipates that in future program years, if it becomes feasible, it may propose to use a full year as the performance period.

Scoring Methods- CMS will score each hospital based on achievement and improvement ranges for each applicable measure. A hospital's score on each measure will be the higher of an achievement score in the performance period or an improvement score, which is determined by comparing the hospital's score in the performance period with its score during a baseline period.

For scoring on achievement, hospitals will be measured based on how much *their* current performance differs from *all other hospitals'* baseline period performance. Points will then be awarded based on the hospital's performance compared to the threshold and benchmark scores for all hospitals. Points will only be awarded for achievement if the hospital's performance during the performance period exceeds a minimum rate

called the "threshold," which is defined by CMS as the 50th percentile of hospital scores during the baseline period.

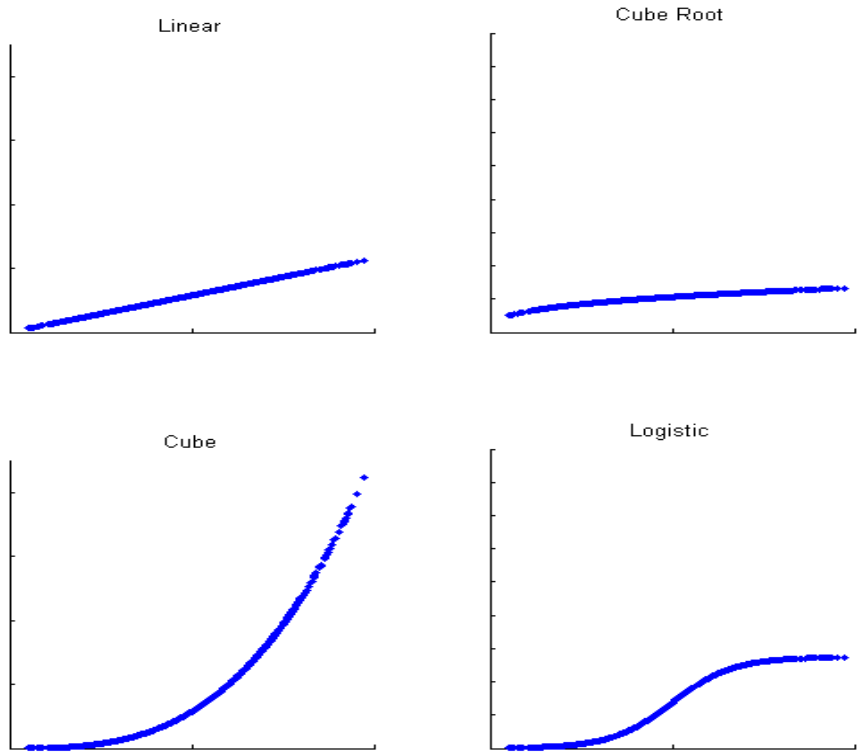
For scoring on improvement, hospitals will be assessed based on how much their *current performance* changes from their own *baseline period performance*. Points will then be awarded based on how much distance they cover between that baseline and the benchmark score. Points will only be awarded for improvement if the hospital's performance improved from their performance during the baseline period.

Finally, CMS will calculate a Total Performance Score (TPS) for each hospital by combining the greater of its achievement or improvement points on each measure to determine a score for each domain, multiplying each domain score by the proposed domain weight and adding the weighted scores together. In FY 2013, the clinical process of care domain will be weighted at 70 percent and the patient experience of care domain will be weighted at 30 percent.

Incentive Payment Calculations- CMS indicates in the Final Rule that the exchange function is the means to translate a hospital's total performance score into the percentage of the value-based incentive payment earned by the hospital, and that the selection of the exact form and slope of the exchange function is of critical importance to how the incentive payments reward performance and encourage hospitals to improve the quality of care they provide.

CMS considered four mathematical exchange function options: straight line (linear); concave curve (cube root function); convex curve (cube function); and S shape (logistic function) as illustrated in Figure 1 below.

Figure 1: Mathematical Exchanged Function Options Considered by CMS



For each of the above exchange function option, CMS evaluated:

- how each option would distribute the value-based incentive payments among hospitals;
- the potential differences between the value-based incentive payment amounts for hospitals that perform poorly and hospitals that perform very well;
- the different marginal incentives created by the different exchange function shapes; and,
- the relative importance of having the exchange function be as simple and straightforward as possible.

The linear function moves more aggressively to higher levels for higher performing hospitals than the cube root function, but not as aggressively as the logistic and cube functions. Due to the fact that the cube root function distributes lower payment amounts to higher performing hospitals, the cube root function creates the narrowest distribution of incentive payments across hospitals. The linear is next, followed by the logistic, and then the cube function, which creates the widest distribution. In the case of the linear shape, the marginal incentive does not vary for higher or lower performing hospitals; the slope of the linear function is constant, so any hospital with a Total

Performance Score that is 0.1 higher than another hospital would receive incrementally the same increase.

When all of the above factors were taken together, CMS determined that the linear exchange function ensures that all hospitals have strong incentives to continually improve the quality of care they provide to their patients. CMS may revisit the issue of the most appropriate exchange function in future rulemaking as they gain more experience under the Hospital VBP program. CMS will notify each hospital of the *estimated* amount of its value-based incentive payment for FY 2013 through its QualityNet account at least 60 days prior to Oct. 1, 2012. CMS will notify each hospital of the *exact* amount of its value-based incentive payment on Nov. 1, 2012

Maryland VBP Exemption- Inpatient acute care hospitals located in the State of Maryland are not currently paid under the IPPS in accordance with a special waiver provided by section 1814(b)(3) of the Act. Despite this waiver, Maryland hospitals continue to meet the definition of a ''subsection (d) hospital" under section 1886(d)(1)(B) of the Affordable Care Act and are, therefore, not exempt from the CMS VBP program. While Maryland hospitals are not subject to the payment reduction under the CMS Hospital Inpatient Quality Reporting (IQR) program, all or nearly all of them submit data to Hospital Compare on a voluntary basis. Therefore, CMS does not believe that requiring Maryland hospitals to participate in the Hospital VBP program would create an additional or duplicative burden, and therefore the Hospital VBP program will apply to acute care hospitals in Maryland. While the collection and submission of quality data for both the VBP and QBR programs does not constitute additional burden for the data collection and submission, participation in both programs would constitute payment changes, up or down, linked with each program.

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

- The report should be received prior to the Secretary's consideration of whether to exercise discretion.
- A State shall submit, in writing and electronically, a report pursuant to section 1886(o)(1)(C)(iv) in a timeframe such that allows CMS-3239-F 126 it to be received no later than October 1, 2011, which is the beginning of the fiscal year prior to the beginning of FY 2013.

- The report should be as specific as possible in describing the quality (and other) measures included and in describing the results achieved over an applicable time period, noting that for the initial report the applicable time period would likely be before and after implementation of the State program.

Minimum Number of Measures and Case Counts for Inclusion in VBP- CMS commissioned Brandeis researchers to check the reliability of the total performance score for hospitals with only 4 measures. The approach used was to randomly select 4, 6, 10, or 14 measures and compare the reliabilities determined using these different sets of measures per hospitals. The research found that using 4 randomly selected measures per hospital did not greatly reduce between-hospital reliability (particularly in terms of rank ordering) from what would have been determined using 10 or 14 measures. The whisker plots and reliability scores demonstrated a clear difference in the distribution of scores for hospitals reporting 4 or more measures compared with those reporting fewer than 4 measures.

Examining hospitals with at least 10 cases for each clinical process measure, the analysis compared the reliability of clinical process measure scores for hospitals according to the number of such measures reported. Whisker plots and reliability scores revealed comparable levels of variation in the process scores for hospitals reporting even a small number of measures as long as the minimum of 10 cases per clinical process measure was met. Based on this analysis, CMS has established the minimum number of cases required for each measure under the proposed Three Domain Performance Scoring Model at 10, which will allow CMS to include more hospitals in the Hospital VBP program.

The reliability of HCAHPS scores was determined through statistical analyses conducted by RAND, the statistical consultant for HCAHPS. RAND's analysis indicates that HCAHPS data does not achieve adequate reliability with a sample of less than 100 completed surveys to ensure that true hospital performance rather than random "noise" is measured. RAND's analysis indicates that HCAHPS data are significantly below 85 percent reliability levels across all HCAHPS dimensions with a sample of less than 100 completed surveys.

Based on the above analysis, in summary, CMS requires the following for inclusion of measures and cases in the VBP performance score calculations:

- Minimum number of cases per measure is 10.
- Minimum number of measures with 10 cases is 4.
- Minimum number of HCAHPS surveys is 100.

5. QBR Expansion Work

HSCRC staff began, in March of this year, convening a QBR Expansion Work Group comprising hospital quality, case mix and program operations staff, MHA staff and other stakeholders to analyze the CMS proposed and final VBP rule and requirements, to determine the updates and expansions that should be made in order to meet or exceed the patient health and cost outcomes of the CMS VBP Program and to deliberate and finalize the recommendations for updating the QBR program for FY 2012 rate adjustments. In the course of the meetings, it was also noted that the Maryland Hospital Acquired Conditions (MHAC) and QBR programs must be proposed together to CMS as meeting or exceeding Medicare's VBP program, and that the QBR Expansion Work Group was specifically focused on updating the QBR program. HSCRC staff convened a QBR Expansion Work Group meeting on 6/29/11 where the group discussed and/or reviewed data models of:

- Preliminary QBR scores including and excluding the HCAHPS scores, using the 50% blended Appropriateness/Opportunity model and apportioning 70% of the score for the process measures and 30% for the HCAHPS scores;
- Use of the linear exchange function to translate the scores into payment using 0.5% of total revenue and revenue neutral scaling across all hospitals;
- Measure differences comparing the VBP and current QBR definitions for benchmark levels, point allocation and determining topped-off status; and
- Improvement point allocation differences with the VBP and QBR models.

Figure 2 below compares the CMS VBP and QBR model definitions. In comparing the topped-off status of the measures, the Work Group noted that two measures, SCIP Inf 1 and SCIP VTE 1, become topped off using the CMS definition as opposed to the QBR definitions. The Work Group additionally noted that aligning our model and definitions with the CMS VBP model and definitions to the extent possible would be at face value better than continuing to use similar but slightly different definitions, particularly in light of the exemption Maryland is planning to seek.

Figure 2. Comparison of CMS VBP and QBR Models.

	CMS VBP	Current QBR
Benchmark	Mean of top decile	95th percentile
Topped-off definition	((90%-75%/standard error)<2 and truncated coefficient of variation <0.1	((95%-75%/standard error)<2
Allocation of Attainment Points	[9 * ((Hospital's performance period score - achievement threshold)/ (benchmark – achievement threshold))] + .5, where the hospital performance period score falls in the range from the achievement threshold to the benchmark.	[9 * ((Hospital's performance period score - achievement threshold)/ (benchmark – achievement threshold))] + 1, where the hospital performance period score falls in the range from the achievement threshold to the benchmark.

Allocation of Improvement Points	[10 * ((Hospital performance period score - Hospital baseline period score)/(Benchmark - Hospital baseline period score))] -.5, where the hospital performance score falls in the range from the hospital's baseline period score to the benchmark.	[9 * ((Hospital performance period score - Hospital baseline period score)/(Benchmark - Hospital baseline period score))] +1, where the hospital performance score falls in the range from the hospital's baseline period score to the benchmark.

DRAFT RECOMMENDATIONS TO UPDATE AND EXPAND THE QBR INITIATIVE BEGINNING WITH FY 2012 RATE ADJUSTMENTS

Based on the analysis conducted, the CMS VBP developments and the deliberations of the QBR Expansion Work Group, staff recommend that the Commission approve the following recommendations:

- Utilize the 16 process measures used for FY 2011 payment adjustments, retiring the pneumonia 5c measure consistent with the CMS clinical recommendation, (see Appendix A), and the additional measures approved for inclusion in the FY'S 2012 and 2013 rate adjustment calculations (see Section 3).
- To mitigate the effects of topped off measures, better distinguish hospital performance, and raise the performance bar, continue to use a hybrid of the Opportunity and Appropriateness model where hospital scores are based 50 percent on Opportunity and 50 percent on Appropriateness for base CY 2009, measurement CY 2010, and rate year FY 2012.
- In light of the blended Opportunity/Appropriateness model, keep the minimum number of 5 process measures reported for inclusion of the hospital in the QBR program.
- Keep the topped off measures in the scoring calculation in light of the blended Appropriateness/Opportunity model recommendation.
- Change the benchmark, topped-off and point allocation definitions in the model to align with the CMS VBP model and definitions, as outlined in Section 5.
- Apportion 70 percent of the hospital scores to process measure performance, and 30 percent to HCAHPS performance.
- Continue to use the CMS minimum case number of 10 for process measures, and adopt the minimum case number of 100 for HCAHPS surveys for inclusion of the measures in the scoring.
- Use the Linear Exchange Function for translating the scores into payment adjustments, consistent with the CMS approach.
- Use the magnitude at risk determined by the Payment Work Group and approved by the Commission in a separate recommendation.
- Prepare and submit to the US HHS Secretary, a VBP program exemption request letter by October 1, 2011.

- To obtain additional information and guidance on specifically how the HHS Secretary will evaluate whether our program is similar to or better than the CMS VBP program in terms of cost and quality outcomes, staff should continue to coordinate and dialogue with CMS staff conducting the hospital quality and VBP work.
- If it becomes evident that materially important changes should be made to the QBR program through the near term dialogue with CMS staff, the staff should recommend such changes to the Commission.

Appendix A: Change in Measure Performance for CY 08 and CY 09 Applied to FY 10 and FY 11 Rates Respectively.

MEASURE	Measure Name	2008 Average	2009 Average	Change
AMI-1	Aspirin at Arrival	96.1%	97.5%	1.31%
AMI-2	Aspirin prescribed at discharge	96.0%	95.4%	-0.65%
AMI-3	Angiotensin converting enzyme inhibitors (ACEI) or angiotensin receptor blockers (ARB) for left ventricular systolic dysfunction (LVSD)	92.4%	93.7%	1.34%
AMI-4	Adult smoking cessation advice/counseling	97.7%	98.8%	1.09%
AMI-5	Beta blocker prescribed at discharge	95.8%	94.9%	-0.88%
HF-1	Discharge instructions	83.5%	86.9%	3.45%
HF-2	Left ventricular systolic function (LVSF) assessment	94.9%	97.1%	2.14%
HF-3	ACEI or ARB for LVSD	91.5%	93.1%	1.56%
HF-4	Adult smoking cessation advice/counseling	96.6%	97.3%	0.61%
PN-2	Pneumococcal vaccination	84.2%	89.0%	4.86%
PN-3b	Blood culture before first antibiotic – Pneumonia	89.9%	91.6%	1.74%
PN-4	Adult smoking cessation advice/counseling	95.6%	95.9%	0.33%
PN-5c	Antibiotic within 6 hours (RETIRED for QBR STARTING CY 1011)	92.6%	93.7%	1.09%
PN-7	Influenza vaccination	78.6%	85.9%	7.26%
SCIP-INF-1	Antibiotic given within 1 hour prior to surgical incision	92.5%	94.7%	2.21%
SCIP-INF-2	Antibiotic selection	96.1%	96.9%	0.77%
SCIP-INF-3	Antibiotic discontinuance within appropriate time period postoperatively	88.6%	91.4%	2.74%

Appendix B: CMS VBP Quality Measures

Clinical Process of Care Measures for FY 2013 Adjustments	
Measure ID	**Measure Description**
Acute Myocardial Infarction	
AMI-7a	Fibrinolytic Therapy Received Within 30 Minutes of Hospital Arrival
AMI-8a	Primary PCI Received Within 90 Minutes of Hospital Arrival
Heart Failure	
HF-1	Discharge Instructions
Pneumonia	
PN-3b	Blood Cultures Performed in the ED Prior to Initial Antibiotic Received in Hospital
PN-6	Initial Antibiotic Selection for CAP in Immunocompetent Patient
Healthcare-associated Infections	
SCIP-Inf-1	Prophylactic Antibiotic Received Within One Hour Prior to Surgical Incision
SCIP-Inf-2	Prophylactic Antibiotic Selection for Surgical Patients
SCIP-Inf-3	Prophylactic Antibiotics Discontinued Within 24 Hours After Surgery End Time
SCIP-Inf-4	Cardiac Surgery Patients with Controlled 6AM Postoperative Serum Glucose
Surgical Care Improvement	
SCIP-Card-2	Surgery Patients on a Beta Blocker Prior to Arrival That Received a Beta Blocker During the Perioperative Period
SCIP-VTE-1	Surgery Patients with Recommended Venous Thromboembolism Prophylaxis Ordered
SCIP-VTE-2	Surgery Patients Who Received Appropriate Venous Thromboembolism Prophylaxis Within 24 Hours Prior to Surgery to 24 Hours After Surgery
Patient Experience of Care Measures	
HCAHPS	Hospital Consumer Assessment of Healthcare Providers &Systems Survey (HCAHPS) · Communication with Nurses · Communication with Doctors · Responsiveness of Hospital Staff · Pain Management · Communication About Medicines · Cleanliness and Quietness of Hospital Environment · Discharge Information · Overall Rating of Hospital

MEASURES FINALIZED FOR THE FISCAL YEAR 2014 HVBP PROGRAM IN THE FINAL RULE:

Mortality Measures:

- Mortality-30-AMI: Acute Myocardial Infarction (AMI) 30-day Mortality Rate
- Mortality-30-HF: Heart Failure (HF) 30-day Mortality Rate
- Mortality-30-PN: Pneumonia (PN) 30-Day Mortality Rate

Hospital Acquired Condition Measures:

- Foreign Object Retained After Surgery
- Air Embolism
- Blood Incompatibility
- Pressure Ulcer Stages III & IV
- Falls and Trauma
- Vascular Catheter-Associated Infections
- Catheter-Associated Urinary Tract Infection (UTI)
- Manifestations of Poor Glycemic Control

<u>AHRQ Patient Safety Indicators (PSIs), Inpatient Quality Indicators (IQIs), and Composite Measures:</u>

- Complication/patient safety for selected indicators (composite)
- Mortality for selected medical conditions (composite)

Final Staff Recommendation on the Reasonableness of Charges (ROC) Methodology and Scaling for the ROC, QBR, and MHAC Initiatives

June 29, 2011

Option 2 - Alternate Proposal, listed in Appendix I, of this final recommendation was approved by the Commission on July 6, 2011. Comments should be sent to Robert Murray, Executive Director, HSCRC 4160 Patterson Avenue, Baltimore MD 21215.

Introduction

This document presents recommendations for: 1) a slight change to the methodology used in the FY 2011 Reasonableness of Charges (ROC) calculations; 2) a modification of an earlier approved recommendation regarding a case mix lag; and 3) the scaling of combined rewards and penalties applied to hospitals based on their relative position on the Commission's ROC ranking and Quality-based Reimbursement (QBR) and Maryland Hospital Acquired Conditions (MHACs) initiatives. The HSCRC scaling methodology is an important policy tool providing strong incentives for hospitals to improve their quality and efficiency over time. The policy has also contributed to Maryland's lower variation in hospital costs versus hospitals nationally.

Current HSCRC policy calls for the revenue neutral scaling of hospitals' position on the approved ROC comparison and allocation of rewards and penalties related to performance on the HCSRC's QBR and MHAC initiatives. The term "scaling" refers to the differential allocation of a pre-determined portion of base hospital revenue based on a distribution of hospital performance related to either relative efficiency or relative quality. The rewards (positive scaled amounts) or penalties (negative scaled amounts) are then applied to each hospital's update factor for that year. Thus, positive net scaling will add to a hospital's update and negative scaling will reduce a hospital's update. The total amounts scaled will be the sum of ROC and Quality scaling results. It should also be noted that ROC scaling permanently impacts a hospital's revenue base, while the scaling amounts applied for Quality performance are applied on a "one-time basis."

This allocation is performed on a "revenue neutral" basis for the system as a whole. This means that the net increases in rates for better performing hospitals are funded entirely by net decreases in rates for poorer performing hospitals.

Background

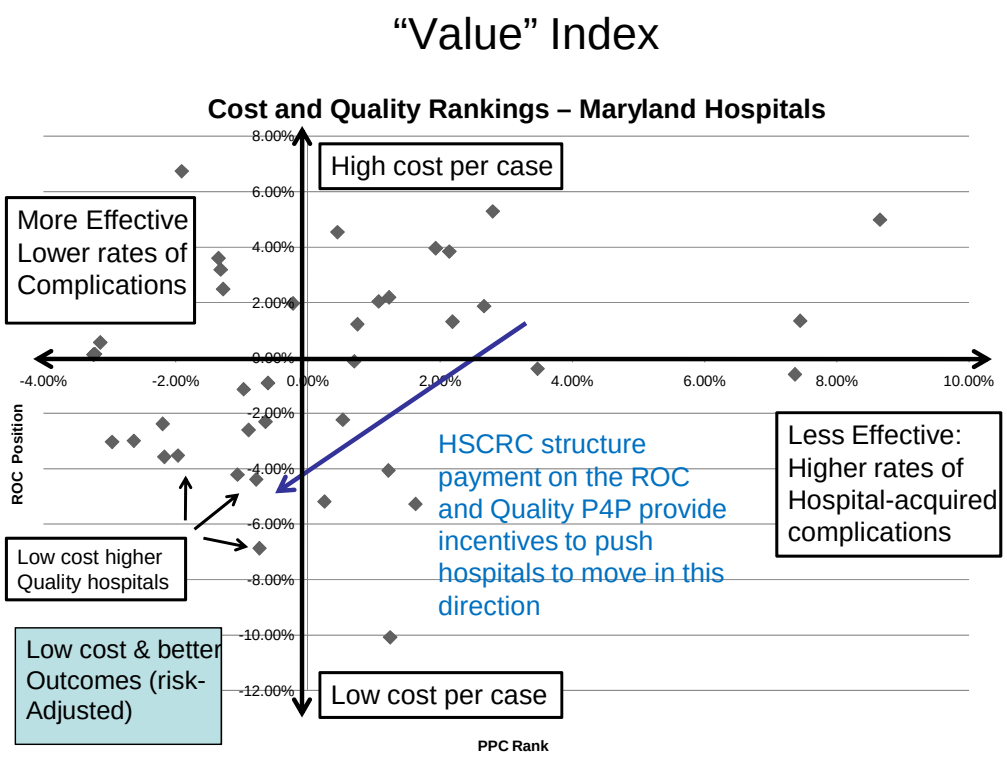
Before FY 2009, the HSCRC did not apply a scaling factor to the ROC. Instead, it set a threshold (traditionally 3.0% above the peer group average) and identified hospitals whose adjusted and combined charge per case and charge per visit were above that threshold as "high charge" facilities. The HSCRC directed staff to negotiate rate reduction agreements (or "spenddown" agreements) with these high cost hospitals. Under a spenddown, the identified hospital would receive something less than full inflation for a period of two to three years until it was at or near the average of its peer group. While negotiated spenddowns did result in the relative improvement of high charge hospitals (and overall compression of hospital adjusted costs on the ROC comparison), hospitals with ROC positions below the average had no means to change their position over time. These hospitals referred to themselves as "stuck hospitals" in that they were stuck in this lower charge position over time with no ability to change their rate structure over time.

With the advent of the HSCRC's two pay-for-performance programs (the QBR and MHACs), which utilized a continuous scaling of a proportion of each hospital's base revenue, the Commission abandoned its spenddown policy and also adopted a continuous scaling approach based on all hospitals' relative ROC positions. Both the FY 2009 and FY 2010 updates included continuous scaling provisions based on hospital relative efficiency (ROC) and relative quality (QBR and MHAC) performance.

Incentivizing Hospitals to Provide the Best Value Care

The combination of rewards and penalties for both relative efficiency and quality is an important step toward recognizing the overall "Value" of hospital care provided for each dollar expended. The chart below illustrates this concept of how the Commission can promote Value and how rewards and penalties based on relative performance can help push hospitals toward a position of providing high quality care and low cost care (lower left quadrant). Continuous scaling of ROC, QBR, and MHAC provides hospitals with strong incentives to gradually improve both efficiency and quality.

Chart 1
Scaling Relative Efficiency and Quality Provide incentives to improve overall Value of Care



Scaling on the Basis of Quality

In the past, the HSCRC scaled only up to 0.5% of base hospital revenue for both the QBR and MHAC (a total of 1.0% of hospital base revenue related to quality). The final scaling magnitudes for the QBR and MHACs were always determined at the end of a particular year because of the hospital industry's preference to see the impact of scaling on individual hospitals in the context of the overall hospital update approved by the Commission. Because of this custom, the precise magnitude scaled was not determined until the end of that year.[1]

[1] Note: over time, both the staff and the hospital and payer industries have suggested that the Commission consider gradually increasing the amount of revenue at risk for relative quality performance in future years so all participants should have anticipated that the scaling related to quality performance would be greater than the original 1.0% magnitude approved in FY 2009 and FY 2010.

More recently the Maryland Hospital Association has proposed that the precise magnitude set aside for quality scaling be determined prospectively. The HSCRC staff is supportive of prospective establishment of standards and targets and thus will recommend scaling magnitudes for QBR and MHAC for the FY 2013 Update (based on FY 2012 actual performance for ROC and MHACs, and CY 2011 performance on QBR) at the August 2011 Commission meeting.

This recommendation for scaling of ROC and Quality performance relates to rate updates applied with FY 2012 rate orders (effective July 1, 2011 for ROC and MHACs and CY 2010 for QBR) and based on hospital relative performance in FY 2011 (year ending June 30, 2011).

Scaling on the Basis of ROC Position

In the past, the staff has considered a variety of ROC scaling magnitudes and structures. In general, staff believes that a continuous scaling of at-risk revenue is the best policy approach. The continuous scaling structure reflects each hospital's relative position most directly and avoids potential inequities in scaling associated with a tiered or step function structure.[2]

As a result, the HSCRC has generally defaulted to a continuous scaling of hospital ROC position. The amount scaled for each hospital has been a proportion (15% in FY 2010) of the difference between its ROC position and its peer group average. Thus, if a hospital was 3.0% above its peer group average, it would have its update factor reduced by 0.45% (+3.0% x 15%). Likewise, a hospital 3.0% below the average would receive an additional 0.45%.[3]

In the past, payer representatives have argued for an even more aggressive scaling approach because the policy was meant to replace what was a highly aggressive spenddown approach to reducing the rate structure of high cost hospitals.

Conversely, hospital representatives have argued for a less aggressive approach based on the argument that the ROC methodology isn't precisely dispositive of a hospital's exact level of relative efficiency, and year-to-year changes in ROC methodology can create some instability in ROC positions.

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[2] Tiered or step-function approaches, which place hospitals in pre-defined brackets based on arbitrary ranges of performance, result in so-called "cliff-effects" in the application of rewards or penalties. These "effects" are the same for any given tier but can increase or drop off dramatically from one tier to another. Hospitals around the edge of the tier can be either highly advantaged or disadvantaged by this approach.

[3] It should be noted that the penalty applied under the continuous scaling approach is far less onerous than the magnitude of reduction applied to spenddown hospitals in any given year. By definition, hospitals on spenddowns would see in excess of 1.0% reductions to their rate updates per year. However, the HSCRC's continuous scaling approach is beneficial to the rate system in that it applies to all hospitals (both high charge and "stuck" hospitals), and it accomplishes the same goal as spenddown arrangements but over a longer period of time.

Concerns regarding changes in ROC position from FY 2010 to FY 2011

The issue of year-to-year instability has been of particular concern to the MHA related to this year's ROC calculation. In FY 2011, the system witnessed a number of policy changes (removal of One Day Stay cases from the Charge per Case methodology and implementation of the HSCRC's Charge per Visit constraint system). Both constitute major changes to Commission methodology and have likely contributed to unanticipated changes in the ROC positions of a number of hospitals.

While these changes in methodology do make it more difficult for hospitals to gauge their relative cost performance (as measured by the ROC), staff believes that the FY 2011 ROC represents an improvement over the FY 2010 methodology and is still highly indicative of high and low cost relative performance. Staff is fully prepared to support this assertion in more detail before the Commission in July.

However, given the concerns raised by the MHA, the staff would offer an alternative scaling approach for the FY 2011 ROC (with scaling results applicable to the FY 2012 updates). This alternative approach establishes a non-scaled bracket of plus or minus 2.0 percent from the average of any given peer group. It proposes scaling a slightly larger proportion of each hospitals position on the ROC down to the expanded 2.0 percent corridor. The result is that hospitals in the +/-2.0 percent bracket receive no ROC scaling. Hospitals above and below the +/- 2.0 percent corridor would be scaled at 25 percent of their position on the ROC down to that 2.0 percent threshold. Consequently, the amounts of revenue scaled (the amount allocated from high cost to low cost hospitals) are reduced significantly. This alternative scenario was discussed during the most recent meetings of the HSCRC Payment Work Group. In response, the MHA proposed an even more diluted scaling approach (expanding the non-scaled bracket to +/- 3.0 percent - scaled at 25 percent of the distance of a hospital's position on the ROC to that threshold). Table 1 show results (both the overall dollar magnitude scaled for the industry as a whole and the impact on individual hospitals) of these different scenarios.

Table 1
Maryland Hospitals' ROC Scaling Simulation Results for Fiscal Year 2011

HOSPID	HOSPITAL NAME	ROC POSITION	Current Policy *Continuous Scaling of 15% of ROC Positions*		Alternate Proposal *Scaling 25% of the Difference in ROC Positions and Limit of 2.00%*		MHA Proposal *Scaling 25% of the Difference in ROC Positions and Limit of 3.00%*	
			Percent Scaled	Revenue Amount Scaled	Percent Scaled	Revenue Amount Scaled	Percent Scaled	Revenue Amount Scaled
Total Amount of Scaled Revenue				**$18,375,238**		**$11,666,146**		**$7,027,763**
210003	Prince Georges Hospital Center	8.76%	-0.87%	-$1,869,716	-0.90%	-$1,942,040	-0.78%	-$1,681,864
210055	Laurel Regional Hospital	7.75%	-0.77%	-$727,672	-0.77%	-$726,720	-0.65%	-$610,192
210016	Washington Adventist Hospital	6.41%	-0.64%	-$1,545,234	-0.59%	-$1,431,472	-0.46%	-$1,125,383
210013	Bon Secours Hospital	5.36%	-0.53%	-$554,747	-0.45%	-$468,312	-0.32%	-$334,499
210061	Atlantic General Hospital	4.64%	-0.46%	-$288,007	-0.35%	-$220,766	-0.22%	-$139,558
210018	Montgomery General Hospital	4.64%	-0.46%	-$612,821	-0.35%	-$469,477	-0.22%	-$296,540
210051	Doctors Community Hospital	4.48%	-0.44%	-$774,279	-0.33%	-$576,833	-0.20%	-$349,760
210022	Suburban Hospital	4.41%	-0.44%	-$904,198	-0.32%	-$665,736	-0.19%	-$396,423
210040	Northwest Hospital Center	4.26%	-0.42%	-$802,152	-0.30%	-$573,343	-0.17%	-$325,367
210009	Johns Hopkins Hospital	3.95%	-0.39%	-$4,957,575	-0.26%	-$3,297,656	-0.13%	-$1,636,096
210058	James Lawrence Kernan Hospital	3.65%	-0.36%	-$274,162	-0.22%	-$166,863	-0.09%	-$66,841
210006	Harford Memorial Hospital	3.27%	-0.32%	-$279,616	-0.17%	-$146,296	-0.04%	-$31,750
210028	St. Mary's Hospital	3.23%	-0.32%	-$338,495	-0.16%	-$173,859	-0.03%	-$33,491
210002	University of Maryland Hospital	2.74%	-0.27%	-$1,967,751	-0.10%	-$716,790	0.00%	$0
210043	Baltimore Washington Medical Ctr	2.24%	-0.22%	-$635,580	-0.03%	-$89,981	0.00%	$0
210012	Sinai Hospital	1.83%	-0.18%	-$874,064	0.00%	$0	0.00%	$0
210054	Southern Maryland Hospital Center	1.77%	-0.18%	-$314,635	0.00%	$0	0.00%	$0
210007	St. Joseph Medical Center	1.69%	-0.17%	-$516,895	0.00%	$0	0.00%	$0
210008	Mercy Medical Center	0.36%	-0.04%	-$116,503	0.00%	$0	0.00%	$0
210011	St. Agnes Hospital	0.07%	-0.01%	-$21,136	0.00%	$0	0.00%	$0
210030	Chester River Hospital Center	0.00%	0.00%	$0	0.00%	$0	0.00%	$0
210045	McCready Memorial Hospital	0.00%	0.00%	$0	0.00%	$0	0.00%	$0
210027	Western MD Regional Medical Ctr	0.00%	0.00%	$0	0.00%	$0	0.00%	$0
210024	Union Memorial Hospital	-0.35%	0.05%	$169,665	0.00%	$0	0.00%	$0
210035	Civista Medical Center	-0.56%	0.08%	$81,876	0.00%	$0	0.00%	$0
210023	Anne Arundel Medical Center	-0.69%	0.10%	$357,701	0.00%	$0	0.00%	$0
210004	Holy Cross Hospital	-0.86%	0.13%	$483,258	0.00%	$0	0.00%	$0
210057	Shady Grove Adventist Hospital	-0.92%	0.14%	$431,728	0.00%	$0	0.00%	$0
210015	Franklin Square Hospital Center	-1.40%	0.21%	$731,075	0.00%	$0	0.00%	$0
210056	Good Samaritan Hospital	-1.41%	0.21%	$522,444	0.00%	$0	0.00%	$0
210044	Greater Baltimore Medical Center	-1.90%	0.28%	$975,865	0.00%	$0	0.00%	$0
210048	Howard County General Hospital	-1.91%	0.29%	$629,864	0.00%	$0	0.00%	$0
210038	Maryland General Hospital	-2.06%	0.31%	$477,447	0.02%	$24,594	0.00%	$0
210019	Peninsula Regional Medical Center	-2.24%	0.34%	$1,068,970	0.06%	$192,995	0.00%	$0
210033	Carroll Hospital Center	-2.48%	0.37%	$640,430	0.12%	$208,026	0.00%	$0
210032	Union of Cecil	-2.98%	0.45%	$505,044	0.24%	$276,748	0.00%	$0
210037	Memorial Hospital at Easton	-3.00%	0.45%	$632,455	0.25%	$351,106	0.00%	$0
210049	Upper Chesapeake Medical Center	-3.01%	0.45%	$830,831	0.25%	$464,472	0.001%	$2,609
210005	Frederick Memorial Hospital	-3.51%	0.53%	$1,312,183	0.38%	$939,286	0.13%	$315,444
210060	Fort Washington Medical Center	-3.79%	0.57%	$213,005	0.45%	$167,730	0.20%	$74,090
210039	Calvert Memorial Hospital	-3.81%	0.57%	$583,043	0.45%	$461,670	0.20%	$206,636
210010	Dorchester General Hospital	-4.42%	0.66%	$314,078	0.61%	$286,663	0.36%	$168,263
210034	Harbor Hospital Center	-4.99%	0.75%	$1,315,032	0.75%	$1,312,818	0.50%	$873,368
210029	Johns Hopkins Bayview Medical Ctr	-5.09%	0.76%	$2,943,195	0.77%	$2,978,958	0.52%	$2,015,774
210017	Garrett County Memorial Hospital	-6.58%	0.99%	$346,199	1.15%	$401,740	0.90%	$314,110
210001	Meritus Medical Center	-8.64%	1.30%	$2,809,851	1.66%	$3,599,340	1.41%	$3,057,468

Source: HSCRC, June 2011.

The Commission will note that each scenario varies in terms of the degree of scaling aggressiveness. Current policy (the continuous scaling approach) scales the greatest amount of revenue from poorer performing to better performing hospitals (approximately $18 million), while the MHA proposed option scales a much lower amount of system revenue (approximately $7 million). In general, staff believes that stronger incentives for improved efficiency are better than weaker incentives.

Cap on Cumulative Scaling for any given Hospital

Current HSCRC ROC Scaling Policy also contemplates a hold-harmless provision for hospitals that receive a cumulative negative scaling amount for the ROC and Quality. This provision caps the negative cumulative impact of combined scaling such that a hospital would not receive a core update of less than 0%.[4] Staff supports retention of this provision.

Revenue Neutrality

As noted above, the ROC and Quality scaling are designed to be revenue neutral for the system as a whole. This means that the amounts allocated to better performing hospitals (rewards) must precisely match the penalties applied to poorer performing hospitals. The amount of revenue available for scaling, then, is a function of both the percentage of at-risk revenue and the magnitude of revenue of the poor performing hospitals.

In the FY 2011 ROC, there are several large hospitals that are eligible for negative scaling. This circumstance results in overall penalties that are in excess of the calculated rewards for better performing hospitals. When this circumstance exists, the excess penalties are first applied to reduce the negative scaling of any individual hospital so as not to drop their update below 0% and then used to reduce proportionately the magnitude of the penalty applied to all other poorly performing hospitals. Staff recommends retention of this revenue neutrality provision.

A summary of the combined scaling amounts (the three ROC scenarios and recommended QBR and MHAC scaling) is presented in Appendix I of this document.

ROC Methodology Change

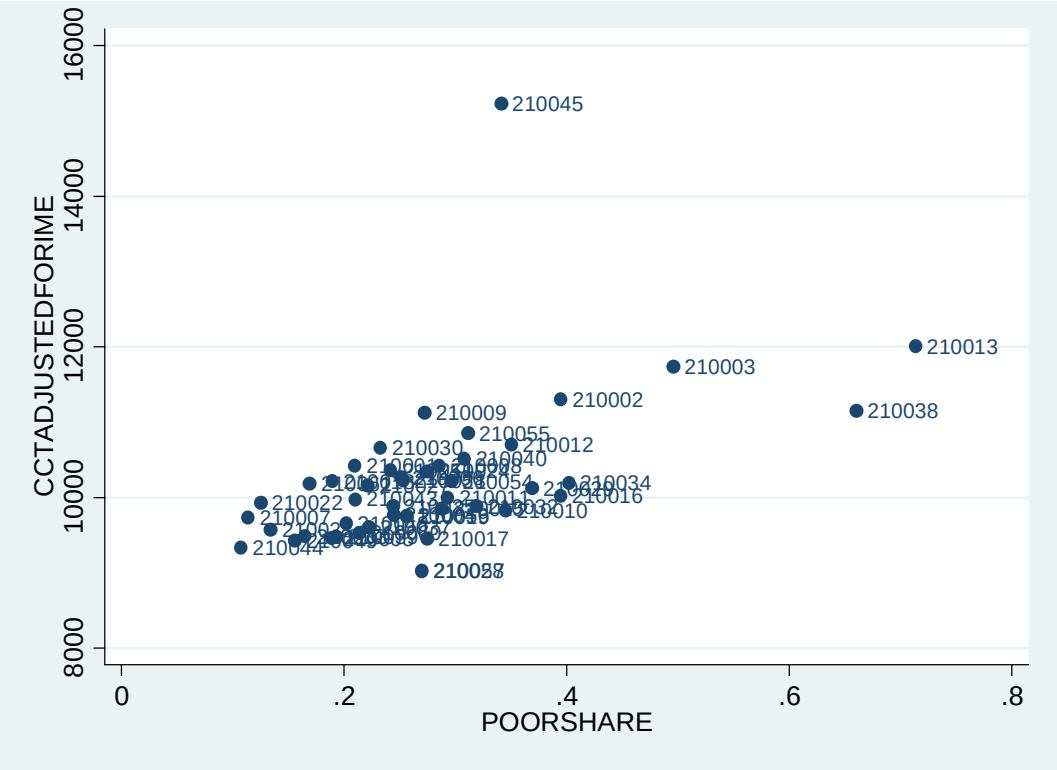
The Commissioners will recall that the ROC is a ranking of hospitals' adjusted charge per case and charge per visit. Adjustments are applied to hospital charge data to account for factors that are built into charges for which a hospital should not be held accountable. Two such examples are the estimated extra cost of a graduate medical education (indirect medical education or IME) program and the estimated additional cost of treating large proportions of indigent patients (disproportionate share or DSH). Costs associated with these activities are estimated by means of a regression. The two variables tend to be highly correlated, because many teaching hospitals are located in urban areas and also service large numbers of lower income patients.

[4] FY 2012 core update is 1.56%. Hospitals with a combined negative scaling amount (ROC plus Quality scaling) of greater than 1.56% would have their adjustment capped at this level so that they would not receive a net negative change to rates in FY 2012.

In performing diagnostics on the regression results, staff discovered that the IME/DSH regression is being unduly influenced by one hospital in particular (McCready hospital on the Eastern Shore). While the two independent variables are highly correlated, McCready does not have a teaching program, and, thus, there is an absence of a confounding effect. This observation, however, is clearly the most extreme outlier on the regression residuals as illustrated by the graph below (McCready is hospital number 21045).

The presence of this outlier observation does have a measurable impact on the regression coefficients, and, thus, staff believes that McCready should be removed from the regression analysis. The hospital, however, would still be included in the final ROC results.

Table 2
Outlier in the IME/DSH Regression Analysis



Case Mix Lag

On June 9, 2010, the Commission approved a staff recommendation to incorporate a three month lag into the data periods used for case mix measurement. This recommendation would move the data period used for case mix indexing from "real time" (the immediate prior fiscal year, July 1 - June 30) to a year period beginning April 1 of the prior year and ending March 31. Hospitals' data submission timelines associated with incorporating real time case mix measurement had delayed Commission staff production of rate orders, and the "case mix lag" aimed to accelerate rate order production. The June 9, 2010 approved recommendation also indicated that technical implementation would be vetted with the MHA Financial Technical Issues Task Force.

This spring, Commission staff worked with MHA's Financial Technical Issues Task Force to implement the case mix lag for the FY 2012 rate orders. No consensus could be reached initially, but as a result of these discussions, staff now recommends a compromise to change the case mix lag to a "case weight lag."

In this recommendation, Commission staff will calculate the case mix index (CMI) based on the prior fiscal year using quarter 1 - quarter 3 final discharge data and quarter 4 preliminary discharge data. Staff will then use the calculated CMI to determine compliance with existing charge-per-case (CPC) and charge-per-visit (CPV) targets. Once final fourth quarter case-mix data are available, compliance and targets would be recalculated, and an adjustment made for any material variance.

Staff will calculate the inpatient case weights based on data from the previous calendar year (a six month lag). Because the volume of cases within inpatient diagnosis-related group (DRG) cells is relatively large and stable, using calendar year data that lags actual experience by six months is likely to result in inpatient case weights that are substantially unchanged from those developed using more current data. However, due to known shifts in outpatient services (e.g., hospital increased utilization of observation services in lieu of inpatient admissions), Commission staff are uncertain of sufficient stability in APGs to utilize calendar year 2010 data for outpatient case weights in the 2012 rate year. Therefore, Commission staff will evaluate the outpatient weights using six and nine months of fiscal year 2011 data.

Appendix II provides a copy of MHA's response to this proposal. Staff will evaluate the efficacy of this approach in the upcoming rate year.

Table 3 indicates the inpatient case mix and weighting data sources for rate year 2012.

Table 3
Rate Year 2012 Case Mix and Case Weight Data Sources - Inpatient

Rate Year	Case Weights	Case Mix Index
July 1, 2011- June 30 2012	Final Discharge Data: • January 1 - December 31, 2010	Final Discharge Data: • July 1, 2010 - March 31, 2011 Preliminary Discharge Data: • April 1 - June 30, 2011

Staff Recommendation

1. ROC Methodology

Recommended modification to the FY 2011 ROC calculation:

The IME/DSH regression is being unduly influenced by one extreme outlier observation (McCready Hospital 210045). This hospital should be excluded from the regression used to quantify the IME and DSH adjustments.

2. Case Weight Lag

Recommended modification from a case mix lag to a weighting lag:

a) Calculate final case mix index based on the prior fiscal year using quarter 1 - quarter 3 final discharge data and quarter 4 preliminary discharge data

b) Calculate case weights -

- Inpatient - based on data from the previous calendar year (a six month lag)
- Outpatient - evaluate the outpatient weights using six and nine months of fiscal year 2011 data

3. ROC, QBR, and MHAC Scaling

a) 0.5 percent of hospital approved revenue for QBR relative performance and other provisions per the Commission approved QBR policy for FY 2011;

b) 1.0 percent of hospital approved revenue for MHAC relative performance;

c) For ROC scaling either option 1: (current policy) 15 percent of the difference between a hospital's position on the ROC and the peer group average (i.e., the peer group average = 0 percent); or option 2: 25 percent of the difference between a hospital's position on the ROC and a 2.0 percent +/- corridor with hospitals in the corridor receiving 0 percent scaling (see Table 1 above);

d) Although it is not represented in the above simulation, staff recommends limiting any given hospital's combined negative scaling to the magnitude of the Commission-approved base update for FY 2012.

e) Additionally, the scaling would be calculated to be revenue neutral for the system as a whole, with any additional amounts generated as a result of the above limitation on negative scaling, to be reallocated first to any capped hospital and second to all other negatively scaled hospitals (as reductions to their calculated offsets).

Appendix I
Combined Scaling Results across Three Different ROC Scaling Scenarios

HOSPID	Hospital Name	Rate Update Factor	Option 1 - Current Policy				Option 2 - Alternate Proposal				Option3 - MHA's Proposal			
			ROC Scaled Revenue Neutral Adjustment	Rate Update Factor (Adjusted for ROC Scaling)	Rate Update Factor (Adjusted for ROC and MHAC Scaling)	Rate Update Factor (Adjusted for ROC, MHAC and QBR Scaling)	ROC Scaled Revenue Neutral Adjustment	Rate Update Factor (Adjusted for ROC Scaling)	Rate Update Factor (Adjusted for ROC and MHAC Scaling)	Rate Update Factor (Adjusted for ROC, MHAC and QBR Scaling)	ROC Scaled Revenue Neutral Adjustment	Rate Update Factor (Adjusted for ROC Scaling)	Rate Update Factor (Adjusted for ROC and MHAC Scaling)	Rate Update Factor (Adjusted for ROC, MHAC and QBR Scaling)
210003	Prince Georges Hospital Center	1.56%	-0.87%	0.69%	-0.14%	**-0.55%**	-0.90%	0.66%	-0.17%	**-0.59%**	-0.78%	0.78%	-0.05%	**-0.47%**
210055	Laurel Regional Hospital	1.56%	-0.77%	0.79%	0.59%	**0.39%**	-0.77%	0.79%	0.59%	**0.40%**	-0.65%	0.91%	0.71%	**0.52%**
210051	Doctors Community Hospital	1.56%	-0.44%	1.12%	0.77%	**0.61%**	-0.33%	1.23%	0.88%	**0.73%**	-0.20%	1.36%	1.01%	**0.86%**
210016	Washington Adventist Hospital	1.56%	-0.64%	0.92%	0.66%	**0.61%**	-0.59%	0.97%	0.70%	**0.66%**	-0.46%	1.10%	0.83%	**0.79%**
210002	University of Maryland Hospital	1.56%	-0.27%	1.29%	0.89%	**0.68%**	-0.10%	1.46%	1.07%	**0.85%**	0.00%	1.56%	1.17%	**0.95%**
210012	Sinai Hospital	1.56%	-0.18%	1.38%	1.03%	**0.87%**	0.00%	1.56%	1.22%	**1.05%**	0.00%	1.56%	1.22%	**1.05%**
210018	Montgomery General Hospital	1.56%	-0.46%	1.10%	0.65%	**0.94%**	-0.35%	1.21%	0.76%	**1.05%**	-0.22%	1.34%	0.89%	**1.18%**
210022	Suburban Hospital	1.56%	-0.44%	1.12%	1.11%	**1.15%**	-0.32%	1.24%	1.23%	**1.26%**	-0.19%	1.37%	1.36%	**1.39%**
210027	Western Maryland Regional Medical Ctr	1.56%	0.00%	1.56%	1.44%	**1.19%**	0.00%	1.56%	1.44%	**1.19%**	0.00%	1.56%	1.44%	**1.19%**
210040	Northwest Hospital Center	1.56%	-0.42%	1.14%	1.22%	**1.19%**	-0.30%	1.26%	1.34%	**1.32%**	-0.17%	1.39%	1.47%	**1.45%**
210030	Chester River Hospital Center	1.56%	0.00%	1.56%	1.52%	**1.29%**	0.00%	1.56%	1.52%	**1.29%**	0.00%	1.56%	1.52%	**1.29%**
210054	Southern Maryland Hospital Center	1.56%	-0.18%	1.38%	1.33%	**1.30%**	0.00%	1.56%	1.50%	**1.47%**	0.00%	1.56%	1.50%	**1.47%**
210009	Johns Hopkins Hospital	1.56%	-0.39%	1.17%	1.22%	**1.34%**	-0.26%	1.30%	1.35%	**1.47%**	-0.13%	1.43%	1.48%	**1.61%**
210057	Shady Grove Adventist Hospital	1.56%	0.14%	1.70%	1.33%	**1.38%**	0.00%	1.56%	1.19%	**1.24%**	0.00%	1.56%	1.19%	**1.24%**
210061	Atlantic General Hospital	1.56%	-0.46%	1.10%	1.11%	**1.39%**	-0.35%	1.21%	1.22%	**1.50%**	-0.22%	1.34%	1.35%	**1.63%**
210015	Franklin Square Hospital Center	1.56%	0.21%	1.77%	1.42%	**1.41%**	0.00%	1.56%	1.21%	**1.20%**	0.00%	1.56%	1.21%	**1.20%**
210013	Bon Secours Hospital	1.56%	-0.53%	1.03%	1.73%	**1.45%**	-0.45%	1.11%	1.82%	**1.53%**	-0.32%	1.24%	1.95%	**1.66%**
210058	James Lawrence Kernan Hospital	1.56%	-0.36%	1.20%	1.47%	**1.47%**	-0.22%	1.34%	1.61%	**1.61%**	-0.09%	1.47%	1.74%	**1.74%**
210043	Baltimore Washington Medical Center	1.56%	-0.22%	1.34%	1.64%	**1.49%**	-0.03%	1.53%	1.83%	**1.68%**	0.00%	1.56%	1.86%	**1.71%**
210024	Union Memorial Hospital	1.56%	0.05%	1.61%	1.46%	**1.58%**	0.00%	1.56%	1.41%	**1.53%**	0.00%	1.56%	1.41%	**1.53%**
210045	McCready Memorial Hospital	1.56%	0.00%	1.56%	1.55%	**1.63%**	0.00%	1.56%	1.55%	**1.63%**	0.00%	1.56%	1.55%	**1.63%**
210023	Anne Arundel Medical Center	1.56%	0.10%	1.66%	1.61%	**1.65%**	0.00%	1.56%	1.51%	**1.55%**	0.00%	1.56%	1.51%	**1.55%**
210007	St. Joseph Medical Center	1.56%	-0.17%	1.39%	1.24%	**1.68%**	0.00%	1.56%	1.41%	**1.85%**	0.00%	1.56%	1.41%	**1.85%**
210035	Civista Medical Center	1.56%	0.08%	1.64%	1.59%	**1.74%**	0.00%	1.56%	1.51%	**1.65%**	0.00%	1.56%	1.51%	**1.65%**
210006	Harford Memorial Hospital	1.56%	-0.32%	1.24%	1.56%	**1.75%**	-0.17%	1.39%	1.72%	**1.91%**	-0.04%	1.52%	1.85%	**2.04%**
210011	St. Agnes Hospital	1.56%	-0.01%	1.55%	1.94%	**1.81%**	0.00%	1.56%	1.95%	**1.82%**	0.00%	1.56%	1.95%	**1.82%**
210056	Good Samaritan Hospital	1.56%	0.21%	1.77%	1.74%	**1.82%**	0.00%	1.56%	1.53%	**1.61%**	0.00%	1.56%	1.53%	**1.61%**
210028	St. Mary's Hospital	1.56%	-0.32%	1.24%	1.57%	**1.89%**	-0.16%	1.40%	1.72%	**2.05%**	-0.03%	1.53%	1.85%	**2.18%**
210060	Fort Washington Medical Center	1.56%	0.57%	2.13%	2.06%	**1.90%**	0.45%	2.01%	1.94%	**1.78%**	0.20%	1.76%	1.69%	**1.53%**
210034	Harbor Hospital Center	1.56%	0.75%	2.31%	1.94%	**1.91%**	0.75%	2.31%	1.94%	**1.90%**	0.50%	2.06%	1.69%	**1.65%**
210004	Holy Cross Hospital	1.56%	0.13%	1.69%	1.87%	**1.92%**	0.00%	1.56%	1.74%	**1.79%**	0.00%	1.56%	1.74%	**1.79%**
210044	Greater Baltimore Medical Center	1.56%	0.28%	1.84%	2.04%	**1.97%**	0.00%	1.56%	1.76%	**1.69%**	0.00%	1.56%	1.76%	**1.69%**
210005	Frederick Memorial Hospital	1.56%	0.53%	2.09%	2.00%	**1.99%**	0.38%	1.94%	1.85%	**1.84%**	0.13%	1.69%	1.60%	**1.59%**
210038	Maryland General Hospital	1.56%	0.31%	1.87%	2.35%	**2.00%**	0.02%	1.58%	2.05%	**1.71%**	0.00%	1.56%	2.04%	**1.69%**
210032	Union of Cecil	1.56%	0.45%	2.01%	1.91%	**2.02%**	0.24%	1.80%	1.71%	**1.82%**	0.00%	1.56%	1.46%	**1.58%**
210048	Howard County General Hospital	1.56%	0.29%	1.85%	1.98%	**2.07%**	0.00%	1.56%	1.70%	**1.78%**	0.00%	1.56%	1.70%	**1.78%**
210008	Mercy Medical Center	1.56%	-0.04%	1.52%	1.92%	**2.16%**	0.00%	1.56%	1.96%	**2.20%**	0.00%	1.56%	1.96%	**2.20%**
210019	Peninsula Regional Medical Center	1.56%	0.34%	1.90%	2.36%	**2.20%**	0.06%	1.62%	2.09%	**1.92%**	0.00%	1.56%	2.03%	**1.86%**
210033	Carroll Hospital Center	1.56%	0.37%	1.93%	2.41%	**2.43%**	0.12%	1.68%	2.16%	**2.18%**	0.00%	1.56%	2.04%	**2.06%**
210037	Memorial Hospital at Easton	1.56%	0.45%	2.01%	2.31%	**2.43%**	0.25%	1.81%	2.11%	**2.23%**	0.00%	1.56%	1.86%	**1.98%**
210039	Calvert Memorial Hospital	1.56%	0.57%	2.13%	2.46%	**2.49%**	0.45%	2.01%	2.34%	**2.37%**	0.20%	1.76%	2.09%	**2.12%**
210029	Johns Hopkins Bayview Medical Center	1.56%	0.76%	2.32%	2.60%	**2.51%**	0.77%	2.33%	2.61%	**2.52%**	0.52%	2.08%	2.36%	**2.27%**
210049	Upper Chesapeake Medical Center	1.56%	0.45%	2.01%	2.39%	**2.58%**	0.25%	1.81%	2.19%	**2.38%**	0.00%	1.56%	1.94%	**2.13%**
210010	Dorchester General Hospital	1.56%	0.66%	2.22%	2.66%	**2.77%**	0.61%	2.17%	2.60%	**2.71%**	0.36%	1.92%	2.35%	**2.46%**
210017	Garrett County Memorial Hospital	1.56%	0.99%	2.55%	2.92%	**2.93%**	1.15%	2.71%	3.08%	**3.09%**	0.90%	2.46%	2.83%	**2.84%**
210001	Meritus Medical Center	1.56%	1.30%	2.86%	2.92%	**3.15%**	1.66%	3.22%	3.28%	**3.51%**	1.41%	2.97%	3.03%	**3.26%**
Statewide Total		1.56%	0.00%	1.56%	1.56%	**1.56%**	0.00%	1.56%	1.56%	**1.56%**	0.00%	1.56%	1.56%	**1.56%**

Source: HSCRC, June 2011.

Appendix II
Maryland Hospital Association Response to Proposed Case Weight Lag

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

June 23, 2011

Robert Murray
Executive Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215-2299

Dear Mr. Murray:

On behalf of our 66 member organizations, the Maryland Hospital Association (MHA) appreciates the opportunity to comment on your June 13 memo outlining changes to the process and data submissions required to establish rate orders for fiscal year 2012. We appreciate your efforts to identify and address factors that delay the issuance of final rate orders, and we believe the approach you have outlined for the coming year is practical and reasonable.

We request that you clarify three points:

1. **Case-mix Data Submission**

   The proposed approach uses preliminary fourth quarter case-mix data to calculate final case-mix index, included cases and visits, and excluded cases and visits for all categories. These calculations are then used to determine compliance with existing charge-per-case (CPC) and charge-per-visit (CPV) targets and to calculate the subsequent year's CPC and CPV targets. Once final fourth quarter case-mix data is available, compliance and targets would be recalculated, and an adjustment made for any material variance.

   We agree with this approach, but ask that you either define "material variance" or settle all variances.

2. **Case-weight lag**

   The proposed approach uses calendar year data to develop case weights for the subsequent year. Because the volume of cases within inpatient diagnosis-related group (DRG) cells is relatively large and stable, using calendar year data that lags actual experience by six months is likely to result in inpatient case weights that are substantially unchanged from those developed using more current data.

   In fiscal year 2011, many hospitals began aggressively utilizing observation services in lieu of inpatient admissions. As a result, it may be important to capture those volumes in the outpatient ambulatory patient group (APG) weights. As the proposed approach appears to recognize, it is unclear whether outpatient volumes within APGs are sufficiently stable to result in similar weights when using calendar year 2010 data compared to fiscal year 2011data. The memo states that HSCRC staff will evaluate the outpatient weights using six and nine months of fiscal year 2011 data.

- more -

We believe it is important to evaluate whether material differences exist between outpatient APG weights based on six months and twelve months of fiscal year 2011 data.

3. **Admission-Readmission Policy**

   We agree that any Admission-Readmission Revenue (ARR) arrangements with the measurement period defined as March 1, 2010 - March 31, 2011 should be modified to coincide with the start of rate year 2012. HSCRC Commissioners approved the final staff recommendation on January 12, 2011; however, the details of how the policy would be implemented are not public.

   We urge Commission staff to publish the operational and technical details of the ARR policy.

Thank you for the opportunity to comment on changes to the process that supports calculation of rate orders. Please contact me at 410-540-5087 with any questions.

Sincerely,

Traci Lynn La Valle

Traci La Valle
Vice President, Financial Policy

cc: Commissioners

Proposal for 2011 Reasonableness-of-Charges (ROC)

Maryland Hospital Association

July 6, 2011

Maryland
Hospital Association

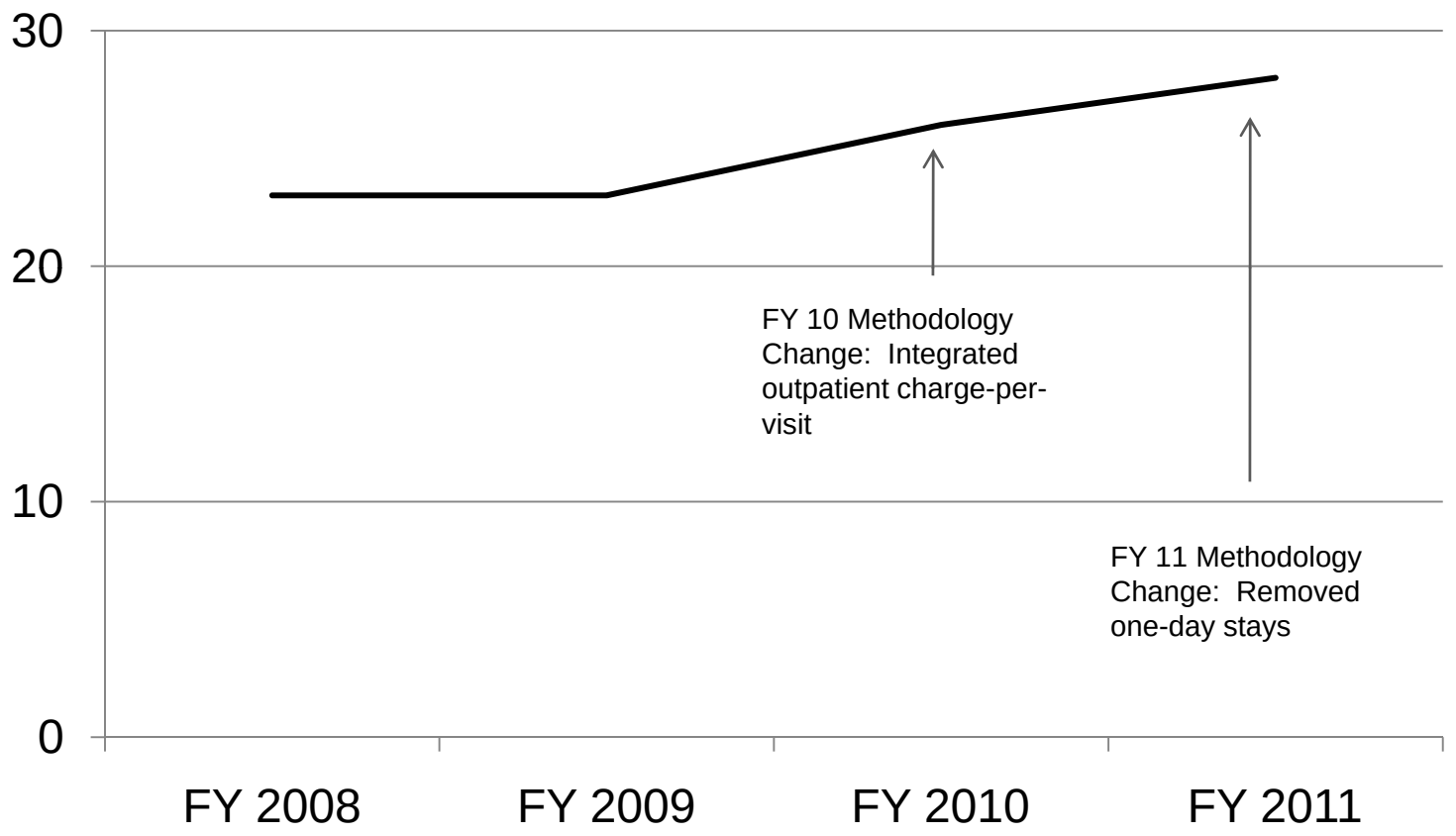
Key Concerns

- Reasonableness-of-Charges (ROC) position compares charges set by HSCRC, not hospital management decisions.
  - Hospitals that reduce costs or increase efficiencies do not improve their position.
- Major methodological changes to 2011 ROC calculation drive change in hospital ROC positions.
  - One-Day Stays (ODS) excluded in fiscal year 2011 calculation result in drastically different positions.
- Rate impact should be mitigated through limited ROC scaling.

Purpose of ROC Analysis and Scaling

- ROC analysis compares charges for an individual hospital relative to its peer group and determines whether rates are reasonable.
- Scaling policy aims to gradually increase rates at hospitals with low ROC positions and reduce rates at hospitals with high positions.
- Results should drive hospitals' ROC positions toward the mean.
  - Since 2009 more hospitals have moved away from their peer group average.

Hospitals with ROC Position Greater than 3 Percent Difference from Peer Group Average



Hospital Management Decisions Do Not Improve ROC Position

- ROC position is determined by rates set by HSCRC.
- Hospital management decisions have no impact on its ROC position and thus does not incentivize hospitals to reduce costs or modify operations.
- Hospitals that reduce cost and operate more efficiently do not improve their position.

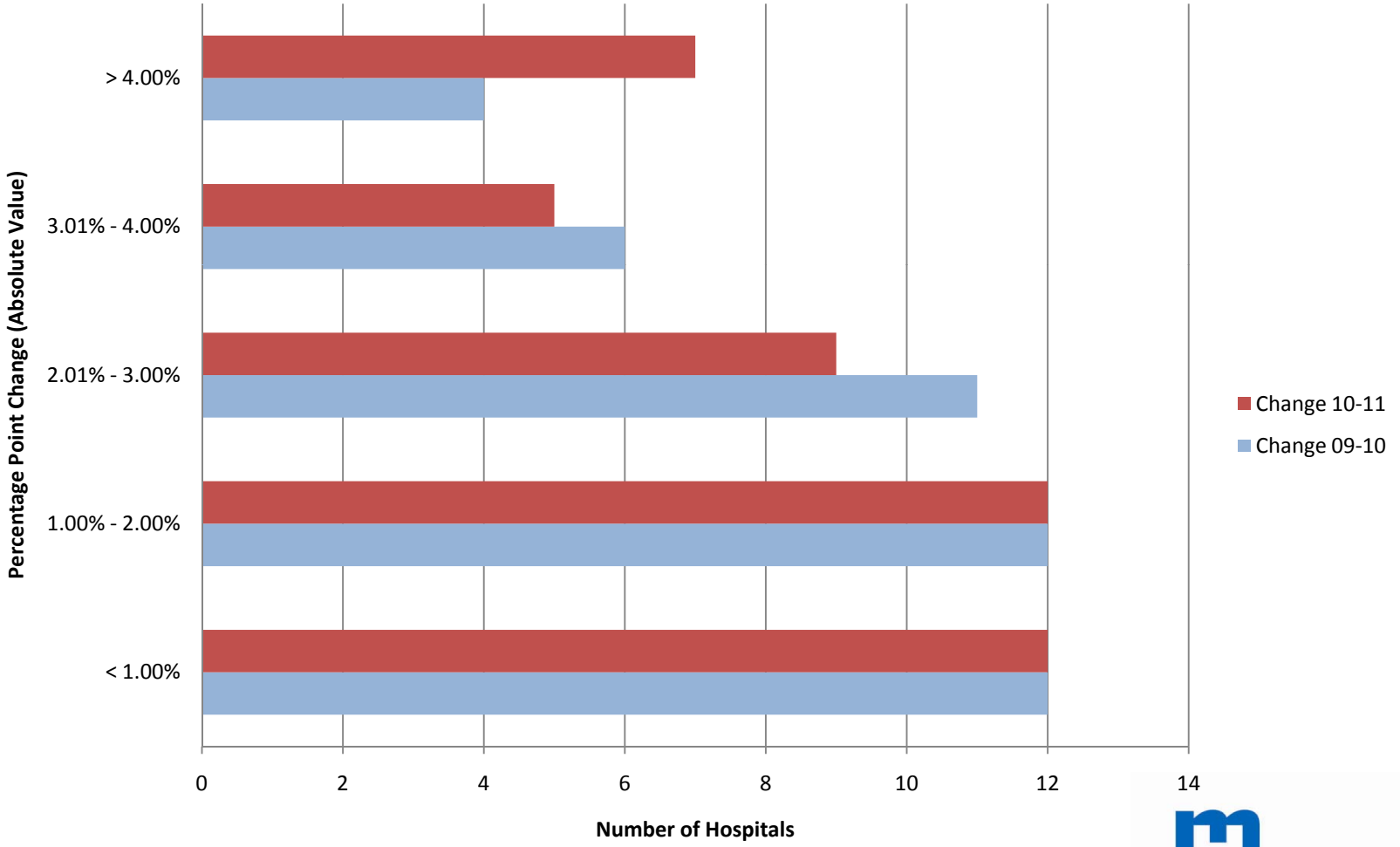
Exclusion of One-Day Stays (ODS)

- ODS cases make up 20 percent of inpatient admissions and 10 percent of inpatient revenue statewide.
- Excluding these cases could adversely affect a hospital's position since ODS are generally assigned lower case weights.
- Excluding ODS creates an apples to oranges comparison from 2010 to 2011.

Effect of Changing Methodology

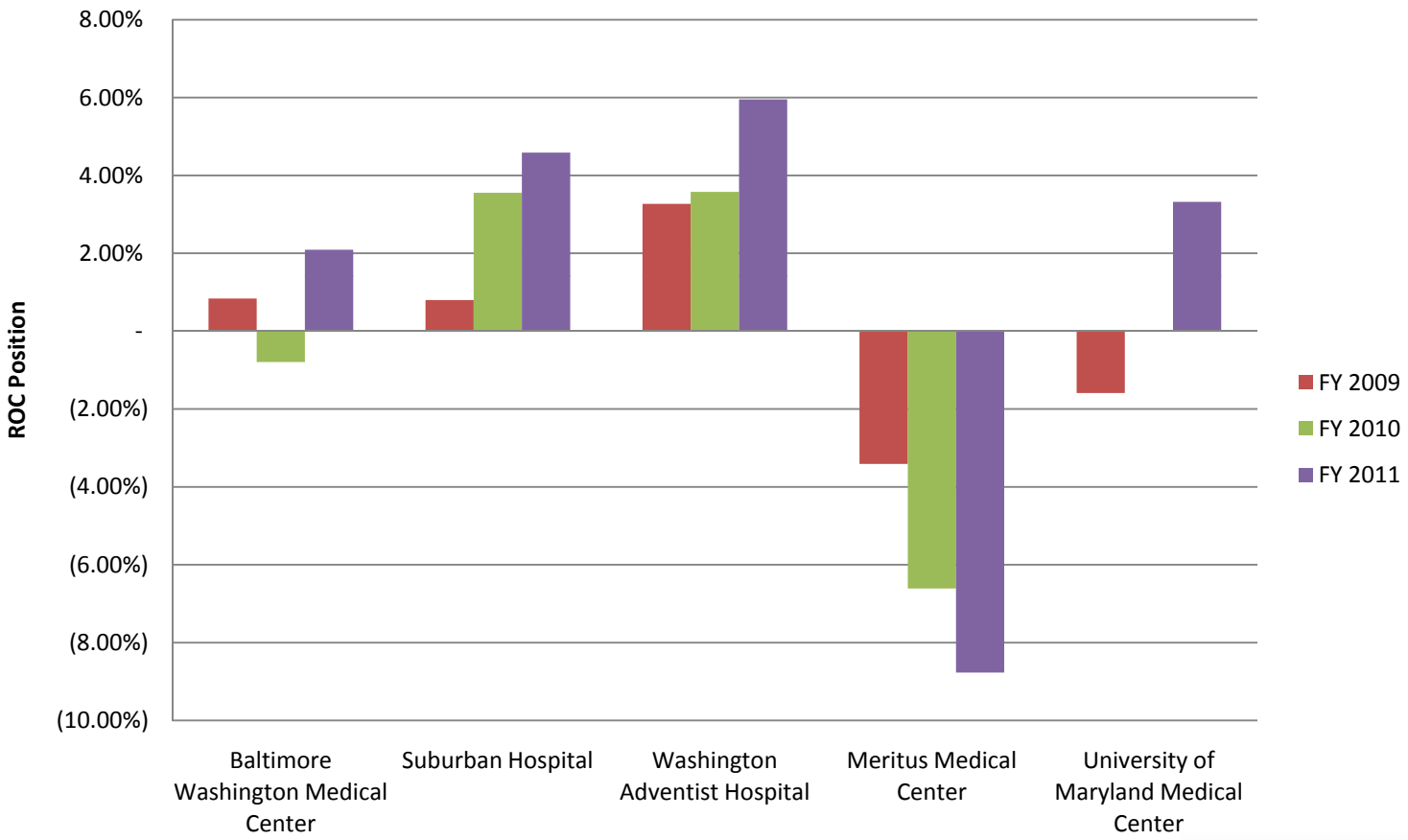
- Instead of having a stabilizing effect, changing methodology creates wider swings in ROC position.
- In 2011, 17 hospitals moved further away from their peer group average.
- In 2011, seven hospitals had a year-to-year change of 4 percentage points or more in ROC position.
  - Excluding the McCready Foundation, this represents an increase of 75 percent over 2010 for hospitals that had an overall swing of 4 percentage points or more.

Year-to-Year Change in Hospital ROC Positions



Maryland Hospital Association

Select Hospitals



Maryland Hospital Association

Moderate Rate Impact

- Relative ROC position is shifting based on changing methodology, not hospital management.
- Limiting the use and impact of ROC on rate adjustments when major methodology changes are implemented is consistent with HSCRC policies.
- In the past, changes were moderated by:
  - Phase-in approach;
  - Limited scaling; and
  - Moratorium on use of the ROC for rate adjustments (2005-2008).

MHA Proposal

- Apply rate adjustments only to those hospitals whose ROC position is 3 percent above or below their peer group average.
- Scaling should be limited to 25 percent of the amount in excess of this 3 percent corridor for those hospitals.
  - Final recommendation represents a compromise from our original proposal of a one-year moratorium on the ROC.

Maryland Hospital Association

Final Thoughts

1. Limit rate adjustments based on the 2011 ROC analysis to only those hospitals whose position is 3 percent above or below their peer group average.
2. ROC analysis does not accurately evaluate hospital efficiency since management decisions to increase efficiency or reduce cost does not affect a hospital's ROC position.
3. A new hospital efficiency measure should be implemented that is responsive to actions taken by the hospital.

The Johns Hopkins Hospital

Discussion of ROC Methodology Issues

July 6, 2011

ROC History

- Key differences between Screens and Reasonableness of Charges ("ROC") Methodology

	Screens	ROC
Data included	Inpatient	Inpatient and Outpatient
Revenue included	Actual charges	Approved rates
Use of the tool	Identified high charge outliers	Redistribution of revenue through continuous scaling *
Impact to revenue	Permanent	Permanent

* The original ROC scaling adjustment was based on bands of ROC results rather than the current continuous scaling

ROC History

- Previously modifications to methodologies were phased in
  - Allowed hospitals the opportunity to respond to methodology changes
  - Provided an opportunity to ensure methodology changes were reasonable and accurate

HSCRC ROC Methodology Changes

- In recent years, HSCRC staff has made numerous methodology changes:
  - New Peer Groups
  - Multiple CPV Developmental and Methodology Changes
  - Intern/Resident/Fellow Count Rule Changes
  - IME Formula/Inclusion of Outpatient CPV logic
  - One Day Stay/Observation Logic
  - Change in DME Calculation
  - Approval of new TPR Hospitals

- We need to ensure that these numerous methodology changes are consistent with the intent of the policy
  - We must ensure accuracy of the data utilized
  - We must consider the use of phase in logic to maintain stability

HSCRC ROC Methodology Changes

- A Hospital cannot affect its ROC position through operations. Movement in ROC position is driven solely by changes in methodology
  - 30% of Hospitals ROC position did not change in a consistent manner with the Spring 2010 ROC Scaling
    - Some hospitals which received positive ROC scaling are more favorable on the Spring 2011 ROC
    - Some hospitals which received negative ROC scaling have further eroded on the Spring 2011 ROC

HSCRC ROC Issues

- TPR Hospitals present additional concerns with the ROC
  - The 10 TPR Hospital represent 11% of Statewide revenue
  - TPR hospitals receive permanent money in rates as an incentive to move to a fixed revenue base
  - CPC and CPV targets in the ROC are imputed to allow TPR hospitals to be comparable to other hospitals
  - TPR hospitals are eligible for positive scaling which results in additional permanent money being added to rates
  - TPR hospitals are protected from negative ROC scaling
- The ROC is a major methodology used to redistribute revenue and thus we need to be careful in applying the scaling logic in times when update factors are less than inflation

Conclusions

- The HSCRC system is undergoing numerous payment changes which will necessitate redefining how we measure "efficiency" in the future
  - Currently there are 10 Hospitals are on the TPR system
  - Approximately 20+ hospitals are in the process of electing ARR system
  - New population based TPR system
  - Other bundling and payment reform initiatives

- As the payment methodology in Maryland moves away from a per case measure the approach to measuring efficiency needs to be redesigned

Report on Results of Uncompensated Care Policy and Final Recommendation to Modify Charity Care Adjustment

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

June 29, 2011

MHA Option 2, listed in Table 1 of this final recommendation, was approved by Commission at the July 6, 2011 public meeting.

Introduction

The purpose of this paper is to report the results of the Uncompensated Care Policy for Fiscal Year 2012 and to recommend for Commission approval an alternative approach to the Charity Care Adjustment under the Commission's Uncompensated Care Policy.

The HSCRC's provision for uncompensated care in hospital rates is one of the unique features of rate regulation in Maryland. Uncompensated care (UCC) includes bad debt and charity care. By recognizing reasonable levels of bad debt and charity care in hospital rates, the system enhances access to hospital care for those citizens who cannot pay for care. The uncompensated care provision in rates is applied prospectively and is meant to be predictive of actual uncompensated care costs in a given year.

The HSCRC uses a regression methodology as a vehicle to predict actual uncompensated care costs in a given year. The uncompensated care methodology has undergone substantial changes over the years since it was initially established. The most recent version of the policy was adopted by the Commission on September 1, 2010.

The uncompensated care regression estimates the relationship between a set of explanatory variables and the rate of uncompensated care observed at each hospital as a percentage of gross patient revenue. Under the current policy, the following variables are included as explanatory variables:

- The proportion of a hospital's total charges from inpatient non-Medicare admissions through the emergency room;
- The proportion of a hospital's total charges from inpatient Medicaid, self-pay, and charity cases;
- The proportion of a hospital's total charges from outpatient Medicaid, self-pay, and charity visits to the emergency room; and
- The proportion of a hospital's total charges from outpatient charges.

The Uncompensated Care Model

The model remains as specified in the current policy. The amount of uncompensated care in rates is computed as follows:

1. Compute a three-year moving average for uncompensated care for each hospital.
2. Use the most recent three years of data to compute the uncompensated care regression (while adding "dummy" variables for each year).
3. Generate a predicted value for the hospital's uncompensated care rate based on the last available year of data.

4. Compute a 50/50 blend of the predicted and three-year moving average as the hospital's amount in rates.
5. Calculate the statewide amount of uncompensated care in rates from this process, and generate the percentage difference between the preliminary amount in rates and the last year of actual experience.
6. Multiply the percentage difference (step 5) by the hospital's preliminary UCC rate (step 4) to get adjusted rates that tie to the State's last year of actual UCC experience (this is referred to as the Revenue Neutrality Adjustment**)**.

The result is the hospital's UCC rate for the next fiscal year.

Discussions Surrounding the Charity Care Adjustment

The Charity Care Adjustment was adopted by the Commission on October 14, 2009. The purpose of the adjustment is to incentivize Maryland hospitals to provide appropriate charity care to eligible patients, and to report to the Commission on the level of charity care provided each year. This policy grew out of provisions included in 2009 legislation (Chapters 310 and 311) which required the Commission to study and make recommendations on incentives for hospitals to provide free and reduced-cost care to patients without the means to pay their hospital bills. The legislation also established a minimum statewide hospital financial assistance threshold (of 150 percent of FPL, later increased by the Commission to 200 percent of FPL), and other requirements relating to hospital debt collection.

Due to a lack of data, the implementation of this adjustment was delayed. The Charity Care Adjustment as part of the Uncompensated Care Policy becomes effective July 1, 2011 (rate year 2012). Under the existing Uncompensated Care Policy, the amount of uncompensated care in rates, before the 100 percent Pooling Level is established, is computed as follows:

1. Take the current policy results by hospital and make the charity care adjustments to them (Charity Care Adjustment is calculated as a fraction of the percentage of hospital gross patient revenue that is Charity Care); and
2. Calculate the revenue neutrality adjustment as a proportional adjustment to neutralize the impact of the Charity Care Adjustment, and adjust the statewide Uncompensated Care Provision to the appropriate level.

The Charity Care Adjustment rewards hospital for providing a higher level of charity care versus their writing off of bad debts. The current adjustment for charity care is based on the percentage of charity care provided as part of UCC. The higher the percentage level of charity care provided, the higher the reward.

In the last six months, a Maryland Hospital Association (MHA) workgroup held several meetings to discuss various issues related to the Charity Care Adjustment under the uncompensated care methodology. The workgroup developed and reviewed alternatives to the current Charity Care Adjustment. On May 5, 2011, HSCRC staff and hospital representatives

reviewed proposals and recommendations from MHA regarding potential changes to the Charity Care Adjustment. MHA's Financial Technical Task Force also discussed these issues at its June 2, 2011 meeting.

The Commission staff has reviewed the two MHA proposals and found that they both provide the desired reward for providing charity care rather than writing off bad debts.

- MHA Option 1 rewards high levels of charity care as a percentage of revenue. It provides more than the current policy to hospitals with high absolute levels of charity care, as compared to high ratios of charity care to UCC. This option is more beneficial to hospitals with high levels of UCC.
- MHA Option 2 is closer to the current policy than Option 1. This option is slightly more favorable than the current policy to hospitals with higher overall levels of UCC, but less so than Option 1.

Table 1 illustrates results of the current policy as well as the two proposed options from the MHA.

Result

The result of this approach is that the prospective amount built into rates across the industry is the amount actually experienced in the previous year of available data, excluding any new estimates for averted bad debt due to Medicaid expansion. If, for example, uncompensated care were $1 billion in FY 2010, this model would establish rates that would deliver $1 billion in fiscal year 2012, provided volumes and rates remain the same.

Appendix I shows the data used in the regression. Appendix II provides policy results from the regression and revenue neutrality adjustment for FY 2012.

Table 1

Summary Results of the Current Policy and the two Proposed Options

Hospid	Hospital Name	FY 2012 Policy Result without Charity Adjustment	Current Policy (Revenue Neutral 20% of Percent of Gross Patient Revenue that is Charity Care)			MHA Option 1 (20% of the Deviation from Statewide Charity Care Average)			MHA Option 2 (20% of the Deviation of Expected Rate from Actual Charity Care)		
			Charity Add on (20%)	FY 2012 Policy Result with Charity Adjustment	Impact of Charity Adjustment	Charity Add on (20%)	FY 2012 Policy Result with Charity Adjustment	Impact of Charity Adjustment	Charity Add on (20%)	FY 2012 Policy Result with Charity Adjustment	Impact of Charity Adjustment
210017	Garrett County Memorial Hospital	9.46%	1.06%	9.87%	0.42%	0.57%	10.03%	0.57%	0.42%	9.88%	0.42%
210003	Prince Georges Hospital	14.49%	1.41%	14.93%	0.44%	0.92%	15.42%	0.92%	0.32%	14.82%	0.32%
210018	Montgomery General Hospital	6.64%	0.79%	6.97%	0.33%	0.30%	6.94%	0.30%	0.27%	6.91%	0.27%
210011	St. Agnes Hospital	7.28%	0.73%	7.51%	0.24%	0.24%	7.51%	0.24%	0.26%	7.53%	0.26%
210055	Laurel Regional Hospital	11.36%	1.12%	11.71%	0.35%	0.63%	11.99%	0.63%	0.22%	11.58%	0.22%
210030	Chester River Hospital Center	9.31%	0.89%	9.58%	0.26%	0.40%	9.72%	0.40%	0.21%	9.53%	0.21%
210027	Braddock Hospital	5.40%	0.55%	5.58%	0.19%	0.06%	5.46%	0.06%	0.21%	5.61%	0.21%
210029	Johns Hopkins Bayview Med. Center	8.78%	0.78%	8.97%	0.19%	0.29%	9.07%	0.29%	0.21%	8.98%	0.21%
210024	Union Memorial Hospital	6.07%	0.56%	6.22%	0.15%	0.07%	6.14%	0.07%	0.18%	6.26%	0.18%
210013	Bon Secours Hospital	18.58%	1.49%	18.83%	0.25%	1.00%	19.58%	1.00%	0.18%	18.76%	0.18%
210033	Carroll County General Hospital	5.87%	0.50%	5.98%	0.11%	0.01%	5.88%	0.01%	0.18%	6.05%	0.18%
210001	Washington County Hospital	8.09%	0.76%	8.30%	0.22%	0.27%	8.36%	0.27%	0.15%	8.24%	0.15%
210002	Univ. of Maryland Medical System	8.78%	0.75%	8.95%	0.16%	0.26%	9.04%	0.26%	0.15%	8.93%	0.15%
210004	Holy Cross Hospital of Silver Spring	7.59%	0.69%	7.78%	0.18%	0.20%	7.80%	0.20%	0.12%	7.71%	0.12%
210016	Washington Adventist Hospital	9.35%	0.77%	9.50%	0.15%	0.28%	9.64%	0.28%	0.09%	9.44%	0.09%
210028	St. Marys Hospital	7.93%	0.62%	8.03%	0.10%	0.13%	8.07%	0.13%	0.08%	8.02%	0.08%
210034	Harbor Hospital Center	9.64%	0.63%	9.63%	-0.00%	0.14%	9.77%	0.14%	0.08%	9.72%	0.08%
210057	Shady Grove Adventist Hospital	7.40%	0.54%	7.45%	0.05%	0.05%	7.45%	0.05%	0.07%	7.47%	0.07%
210045	McCready Foundation, Inc.	11.83%	0.92%	11.96%	0.13%	0.43%	12.26%	0.43%	0.03%	11.86%	0.03%
210037	Memorial Hospital at Easton	6.40%	0.34%	6.33%	-0.07%	-0.15%	6.25%	-0.15%	0.02%	6.42%	0.02%
210044	Greater Baltimore Medical Center	4.09%	0.24%	4.07%	-0.02%	-0.25%	3.84%	-0.25%	0.02%	4.10%	0.02%
210038	Maryland General Hospital	12.45%	0.76%	12.39%	-0.05%	0.27%	12.71%	0.27%	0.01%	12.46%	0.01%
210010	Dorchester General Hospital	8.88%	0.37%	8.68%	-0.20%	-0.12%	8.76%	-0.12%	0.01%	8.89%	0.01%
210012	Sinai Hospital	7.40%	0.40%	7.32%	-0.08%	-0.09%	7.31%	-0.09%	-0.01%	7.39%	-0.01%
210022	Suburban Hospital Association,Inc	4.98%	0.34%	5.00%	0.01%	-0.15%	4.83%	-0.15%	-0.01%	4.97%	-0.01%
210015	Franklin Square Hospital	8.16%	0.42%	8.05%	-0.11%	-0.07%	8.09%	-0.07%	-0.02%	8.14%	-0.02%
210009	Johns Hopkins Hospital	5.87%	0.28%	5.76%	-0.10%	-0.21%	5.65%	-0.21%	-0.02%	5.84%	-0.02%
210056	Good Samaritan Hospital	6.20%	0.39%	6.19%	-0.01%	-0.10%	6.10%	-0.10%	-0.04%	6.16%	-0.04%
210008	Mercy Medical Center, Inc.	7.86%	0.56%	7.90%	0.04%	0.07%	7.93%	0.07%	-0.04%	7.82%	-0.04%
210019	Peninsula Regional Medical Center	6.66%	0.40%	6.62%	-0.04%	-0.10%	6.56%	-0.10%	-0.07%	6.59%	-0.07%
210023	Anne Arundel General Hospital	4.76%	0.27%	4.71%	-0.04%	-0.23%	4.53%	-0.23%	-0.08%	4.67%	-0.08%
210039	Calvert Memorial Hospital	7.42%	0.32%	7.26%	-0.15%	-0.17%	7.25%	-0.17%	-0.12%	7.30%	-0.12%
210048	Howard County General Hospital	6.70%	0.31%	6.58%	-0.12%	-0.18%	6.52%	-0.18%	-0.12%	6.58%	-0.12%
210061	Atlantic General Hospital	7.16%	0.37%	7.06%	-0.10%	-0.12%	7.03%	-0.12%	-0.13%	7.03%	-0.13%
210035	Civista Medical Center	7.91%	0.33%	7.73%	-0.18%	-0.16%	7.75%	-0.16%	-0.14%	7.77%	-0.14%
210005	Frederick Memorial Hospital	6.57%	0.26%	6.41%	-0.16%	-0.23%	6.34%	-0.23%	-0.15%	6.42%	-0.15%
210007	St. Josephs Hospital	4.04%	0.18%	3.96%	-0.08%	-0.31%	3.73%	-0.31%	-0.19%	3.85%	-0.19%
210043	North Arundel General Hospital	8.29%	0.35%	8.11%	-0.18%	-0.14%	8.15%	-0.14%	-0.21%	8.08%	-0.21%
210049	Upper Chesepeake Medical Center	7.07%	0.22%	6.84%	-0.23%	-0.27%	6.79%	-0.27%	-0.28%	6.79%	-0.28%
210040	Northwest Hospital Center, Inc.	8.58%	0.32%	8.35%	-0.23%	-0.18%	8.40%	-0.18%	-0.30%	8.28%	-0.30%
210054	Southern Maryland Hospital	8.67%	0.27%	8.39%	-0.28%	-0.22%	8.45%	-0.22%	-0.35%	8.32%	-0.35%
** 210058	James Lawrence Kernan Hospital	5.14%	0.13%	4.94%	-0.20%	-0.36%	4.77%	-0.36%	-0.44%	4.69%	-0.44%
210032	Union Hospital of Cecil County	9.94%	0.21%	9.52%	-0.42%	-0.28%	9.65%	-0.28%	-0.49%	9.45%	-0.49%
210006	Harford Memorial Hospital	11.25%	0.27%	10.81%	-0.43%	-0.22%	11.03%	-0.22%	-0.50%	10.74%	-0.50%
210051	Doctors Community Hospital	10.01%	0.09%	9.48%	-0.53%	-0.40%	9.61%	-0.40%	-0.51%	9.50%	-0.51%
210060	Fort Washington Medical Center	12.93%	0.27%	12.38%	-0.54%	-0.22%	12.71%	-0.22%	-0.69%	12.24%	-0.69%
	STATE-WIDE	7.48%	0.49%	7.48%	0.00%	0.00%	7.48%	0.00%	0.49%	7.48%	0.00%

***** James Lawrence Kernan Hospital was excluded in the Regression Analysis***

Staff Recommendation on the Charity Care Adjustment under the Uncompensated Care Policy

The current policy and both MHA options provide the desired reward for charity care rather than bad debts.

Staff, therefore, recommends that the Commission continue with current policy or adopt either of the MHA proposals.

Staff will also requests that the Commission waive the sixty day comment period so that this recommendation may be considered for final approval.

Appendix I
Fiscal Year 2010 Data Used in Regression for FY 2012

Hospid	Hospital Name	Inpatient Medicaid Charges ($)	Inpatient Non-Medicare Charges through the ER ($)	Inpatient Self-Pay and Charity Charges ($)	Outpatient Medicaid Charges through the ER ($)	Outpatient Self-Pay and Charity Charges through the ER ($)	Outpatient Revenue ($)	UCC in Rates (July 1, 2009)	Gross Patient Revenue ($)	Uncompensated Care ($)
210001	Washington County Hospital	17,981,812	38,813,443	7,529,764	7,465,977	5,373,597	87,275,100	6.55%	$250,295,900	$22,951,774
210002	Univ. of Maryland Medical System	185,982,502	227,900,964	23,914,953	21,990,481	9,582,288	254,705,700	8.56%	$1,013,735,200	$94,751,955
210003	Prince Georges Hospital	64,420,726	82,208,120	11,929,732	7,789,720	10,265,205	57,709,800	13.19%	$251,597,300	$40,005,783
210004	Holy Cross Hospital of Silver Spring	53,513,979	75,421,021	19,881,531	6,087,585	8,161,670	109,174,300	6.30%	$411,325,700	$34,520,608
210005	Frederick Memorial Hospital	20,683,096	51,663,856	7,052,691	5,104,299	3,736,349	103,739,800	5.55%	$282,475,300	$18,271,834
210006	Harford Memorial Hospital	8,388,861	23,882,345	1,872,245	3,827,004	2,733,727	40,348,900	8.73%	$100,141,200	$11,457,614
210007	St. Josephs Hospital	16,216,173	41,845,594	4,868,362	3,045,790	2,701,369	124,372,100	3.05%	$375,076,400	$19,858,867
210008	Mercy Medical Center, Inc.	51,222,412	38,546,071	6,141,608	12,070,737	5,791,922	174,842,400	7.02%	$388,727,200	$34,760,814
210009	Johns Hopkins Hospital	257,183,325	215,159,781	7,323,440	32,124,220	14,258,052	575,151,700	5.78%	$1,709,103,100	$77,013,354
210010	Dorchester General Hospital	5,534,374	8,902,128	1,319,346	2,762,873	1,241,541	22,356,200	5.46%	$51,961,600	$4,064,801
210011	St. Agnes Hospital	40,290,498	70,157,571	13,353,901	9,238,119	5,834,110	104,861,900	6.42%	$357,504,800	$25,581,943
210012	Sinai Hospital	78,462,062	92,794,832	7,484,764	18,851,202	8,654,183	210,732,200	6.96%	$619,723,100	$38,469,228
210013	Bon Secours Hospital	34,294,313	45,489,055	10,514,483	8,012,336	7,208,489	37,102,600	14.91%	$121,320,200	$22,654,618
210015	Franklin Square Hospital	55,039,853	87,879,236	8,904,354	13,367,437	7,454,163	129,851,400	7.53%	$422,965,000	$29,637,057
210016	Washington Adventist Hospital	41,947,550	62,160,349	14,622,201	5,235,141	6,552,784	59,490,728	7.94%	$265,356,838	$26,530,073
210017	Garrett County Memorial Hospital	3,225,332	5,281,503	658,513	1,611,314	923,425	18,798,500	5.19%	$39,731,000	$4,470,966
210018	Montgomery General Hospital	9,397,368	30,571,113	5,255,509	2,390,187	1,994,896	46,991,500	6.32%	$149,773,600	$11,153,051
210019	Peninsula Regional Medical Center	31,139,952	63,566,259	12,123,206	8,259,500	5,118,568	123,535,700	5.10%	$394,310,100	$29,126,732
210022	Suburban Hospital Association,Inc	6,483,071	44,600,773	7,716,384	656,519	1,681,384	68,029,800	4.98%	$234,114,100	$11,612,760
210023	Anne Arundel General Hospital	22,077,233	51,477,487	6,250,121	4,128,332	4,038,687	151,386,300	4.43%	$415,890,500	$21,029,941
210024	Union Memorial Hospital	41,744,746	61,382,397	8,626,881	6,977,768	4,996,807	104,691,900	5.84%	$399,909,200	$23,764,291
210027	Braddock Hospital	20,384,075	35,394,343	5,379,422	4,051,863	1,775,297	107,183,700	3.18%	$278,853,100	$17,457,994
210028	St. Marys Hospital	9,188,547	19,765,887	3,069,720	4,921,945	2,394,289	60,774,915	6.70%	$125,978,346	$10,599,435
210029	Johns Hopkins Bayview Med. Center	81,390,655	96,662,905	10,424,945	10,203,830	9,156,524	179,732,200	7.93%	$518,108,900	$45,414,424
210030	Chester River Hospital Center	3,811,035	6,888,708	789,947	1,892,833	981,888	29,095,400	6.76%	$59,939,400	$6,450,757
210032	Union Hospital of Cecil County	12,597,490	18,443,959	3,095,896	6,339,185	3,404,247	60,450,200	6.52%	$126,899,200	$14,292,926
210033	Carroll County General Hospital	16,414,863	44,145,045	194,270	2,984,969	1,995,277	56,308,200	4.84%	$202,238,000	$11,049,827
210034	Harbor Hospital Center	38,075,005	43,282,764	6,619,784	8,605,938	4,353,457	51,948,500	8.48%	$197,161,200	$17,496,840
210035	Civista Medical Center	8,934,612	23,550,668	3,087,369	3,451,357	2,692,459	37,032,600	6.06%	$111,481,500	$8,512,574
210037	Memorial Hospital at Easton	13,762,361	22,035,481	1,649,803	5,053,207	2,285,200	65,490,600	4.62%	$160,769,200	$9,065,875
210038	Maryland General Hospital	58,482,095	48,934,982	5,663,475	7,216,059	3,668,893	42,063,200	11.15%	$178,831,900	$20,704,984
210039	Calvert Memorial Hospital	7,950,379	20,032,186	2,381,372	3,554,100	1,812,008	58,628,200	5.27%	$120,112,700	$8,860,676
210040	Northwest Hospital Center, Inc.	12,018,431	42,503,830	5,000,620	6,807,363	4,531,805	83,301,200	7.32%	$214,481,500	$19,627,111
210043	North Arundel General Hospital	20,353,614	64,109,529	7,993,540	9,199,428	8,613,665	117,605,600	6.95%	$332,045,200	$28,277,716
210044	Greater Baltimore Medical Center	16,895,313	46,402,335	2,725,470	4,982,863	3,510,262	180,923,700	2.96%	$412,551,300	$14,750,652
210045	McCready Foundation, Inc.	572,861	1,430,041	395,982	1,499,743	759,761	12,054,183	6.75%	$18,681,464	$2,660,531
210048	Howard County General Hospital	20,251,328	44,948,197	6,091,779	5,486,368	4,416,599	84,625,100	5.59%	$244,838,400	$15,866,876
210049	Upper Chesepeake Medical Center	12,508,072	38,837,879	1,571,331	5,471,373	3,920,645	89,314,300	5.48%	$226,352,700	$16,739,078
210051	Doctors Community Hospital	16,828,627	51,909,540	4,941,425	4,665,164	4,875,855	72,283,200	8.82%	$196,074,400	$18,244,300
210054	Southern Maryland Hospital	23,588,328	47,929,774	8,801,425	6,388,081	3,697,341	62,116,300	7.84%	$223,251,200	$20,321,916
210055	Laurel Regional Hospital	11,622,687	21,450,763	4,029,082	2,904,386	4,215,733	36,930,800	10.45%	$102,846,900	$13,415,586
210056	Good Samaritan Hospital	24,877,660	48,163,828	5,801,240	7,102,517	4,712,116	87,049,100	5.20%	$294,819,900	$19,549,695
210057	Shady Grove Adventist Hospital	31,296,281	64,098,310	9,756,452	7,746,586	7,047,760	111,257,437	7.33%	$335,364,985	$22,204,015
** 210058	James Lawrence Kernan Hospital	5,256,932	0	847,562	0	0	35,543,200	5.87%	$101,537,800	$8,594,918
210060	Fort Washington Medical Center	1,099,252	10,273,933	2,143,989	1,436,609	2,082,203	21,528,452	10.90%	$44,747,960	$6,260,194
210061	Atlantic General Hospital	2,444,625	11,263,172	2,006,409	1,951,486	1,987,740	43,745,000	4.68%	$84,190,900	$6,721,663
	STATE-WIDE	1,515,834,366	2,292,161,957	291,806,298	304,913,792	207,194,239	4,392,133,815	6.57%	$13,167,195,393	$984,828,627

***** James Lawrence Kernan Hospital was excluded in the Regression Analysis***

Appendix II
Policy Results from the Regression and Revenue Neutrality Adjustment for FY 2012

Hospid	Hospital Name	UCC in Rates (July 1, 2009)	Actual UCC for FY '10	Adjusted UCC for FY '10 (Includes Averted Bad Debt)	Predicted UCC	FY '08 - FY '10 UCC AVERAGE	50/ 50 BLENDED UCC AVERAGE	Revenue Neutrality Adjustment	Policy Results without Charity Care Adjustemnt	Dollar Amount ($)
210001	Washington County Hospital	6.55%	8.30%	9.17%	7.71%	8.44%	8.07%	1.0018	8.09%	20,240,117
210002	Univ. of Maryland Medical System	8.56%	8.20%	9.35%	8.49%	9.04%	8.77%	1.0018	8.78%	89,027,101
210003	Prince Georges Hospital	13.19%	14.90%	15.90%	14.06%	14.88%	14.47%	1.0018	14.49%	36,468,671
210004	Holy Cross Hospital of Silver Spring	6.30%	7.84%	8.39%	7.58%	7.57%	7.58%	1.0018	7.59%	31,227,995
210005	Frederick Memorial Hospital	5.55%	5.67%	6.47%	7.23%	5.88%	6.56%	1.0018	6.57%	18,551,297
210006	Harford Memorial Hospital	8.73%	10.58%	11.44%	10.77%	11.68%	11.23%	1.0018	11.25%	11,261,443
210007	St. Josephs Hospital	3.05%	5.07%	5.29%	3.95%	4.11%	4.03%	1.0018	4.04%	15,141,171
210008	Mercy Medical Center, Inc.	7.02%	8.19%	8.94%	7.67%	8.02%	7.85%	1.0018	7.86%	30,552,648
210009	Johns Hopkins Hospital	5.78%	4.07%	4.51%	6.25%	5.47%	5.86%	1.0018	5.87%	100,261,464
210010	Dorchester General Hospital	5.46%	4.87%	7.82%	10.64%	7.08%	8.86%	1.0018	8.88%	4,611,863
210011	St. Agnes Hospital	6.42%	6.42%	7.16%	8.17%	6.35%	7.26%	1.0018	7.28%	26,012,090
210012	Sinai Hospital	6.96%	5.57%	6.21%	7.58%	7.19%	7.39%	1.0018	7.40%	45,862,289
210013	Bon Secours Hospital	14.91%	17.84%	18.67%	19.72%	17.38%	18.55%	1.0018	18.58%	22,542,522
210015	Franklin Square Hospital	7.53%	5.98%	7.01%	8.96%	7.32%	8.14%	1.0018	8.16%	34,496,227
210016	Washington Adventist Hospital	7.94%	9.34%	10.00%	9.31%	9.36%	9.34%	1.0018	9.35%	24,817,243
210017	Garrett County Memorial Hospital	5.19%	8.73%	11.25%	8.99%	9.89%	9.44%	1.0018	9.46%	3,757,156
210018	Montgomery General Hospital	6.32%	7.05%	7.45%	7.09%	6.17%	6.63%	1.0018	6.64%	9,949,899
210019	Peninsula Regional Medical Center	5.10%	6.38%	7.39%	6.61%	6.69%	6.65%	1.0018	6.66%	26,260,649
210022	Suburban Hospital Association,Inc	4.98%	4.82%	4.96%	5.00%	4.95%	4.97%	1.0018	4.98%	11,662,668
210023	Anne Arundel General Hospital	4.43%	4.72%	5.06%	4.89%	4.60%	4.75%	1.0018	4.76%	19,778,637
210024	Union Memorial Hospital	5.84%	5.12%	5.94%	5.98%	6.14%	6.06%	1.0018	6.07%	24,279,829
210027	Braddock Hospital	3.18%	4.69%	6.26%	5.52%	5.26%	5.39%	1.0018	5.40%	15,051,807
210028	St. Marys Hospital	6.70%	7.36%	8.41%	9.23%	6.61%	7.92%	1.0018	7.93%	9,995,721
210029	Johns Hopkins Bayview Med. Center	7.93%	7.83%	8.77%	8.50%	9.02%	8.76%	1.0018	8.78%	45,469,736
210030	Chester River Hospital Center	6.76%	9.24%	10.76%	7.52%	11.07%	9.30%	1.0018	9.31%	5,582,809
210032	Union Hospital of Cecil County	6.52%	9.50%	11.26%	10.37%	9.46%	9.92%	1.0018	9.94%	12,609,995
210033	Carroll County General Hospital	4.84%	4.39%	5.46%	6.61%	5.11%	5.86%	1.0018	5.87%	11,876,601
210034	Harbor Hospital Center	8.48%	7.48%	8.87%	10.77%	8.47%	9.62%	1.0018	9.64%	18,997,644
210035	Civista Medical Center	6.06%	6.42%	7.64%	9.04%	6.74%	7.89%	1.0018	7.91%	8,813,565
210037	Memorial Hospital at Easton	4.62%	4.34%	5.64%	7.42%	5.35%	6.39%	1.0018	6.40%	10,288,564
210038	Maryland General Hospital	11.15%	10.17%	11.58%	13.06%	11.79%	12.42%	1.0018	12.45%	22,255,669
210039	Calvert Memorial Hospital	5.27%	6.01%	7.38%	8.56%	6.24%	7.40%	1.0018	7.42%	8,907,386
210040	Northwest Hospital Center, Inc.	7.32%	8.40%	9.15%	8.76%	8.37%	8.56%	1.0018	8.58%	18,399,789
210043	North Arundel General Hospital	6.95%	7.64%	8.52%	8.48%	8.07%	8.27%	1.0018	8.29%	27,526,207
210044	Greater Baltimore Medical Center	2.96%	3.13%	3.58%	5.09%	3.08%	4.08%	1.0018	4.09%	16,872,324
210045	McCready Foundation, Inc.	6.75%	12.06%	14.24%	12.06%	11.56%	11.81%	1.0018	11.83%	2,210,028
210048	Howard County General Hospital	5.59%	5.85%	6.48%	7.71%	5.67%	6.69%	1.0018	6.70%	16,413,500
210049	Upper Chesepeake Medical Center	5.48%	6.74%	7.40%	7.37%	6.74%	7.05%	1.0018	7.07%	15,992,769
210051	Doctors Community Hospital	8.82%	8.28%	9.30%	10.14%	9.84%	9.99%	1.0018	10.01%	19,625,544
210054	Southern Maryland Hospital	7.84%	8.47%	9.10%	8.54%	8.77%	8.66%	1.0018	8.67%	19,365,728
210055	Laurel Regional Hospital	10.45%	12.22%	13.04%	10.61%	12.07%	11.34%	1.0018	11.36%	11,683,545
210056	Good Samaritan Hospital	5.20%	5.85%	6.63%	6.79%	5.59%	6.19%	1.0018	6.20%	18,276,243
210057	Shady Grove Adventist Hospital	7.33%	6.32%	6.62%	8.16%	6.61%	7.39%	1.0018	7.40%	24,815,057
** 210058	James Lawrence Kernan Hospital	5.87%	7.75%	8.46%	2.86%	7.41%	5.14%	0.0000	5.14%	5,214,356
210060	Fort Washington Medical Center	10.90%	13.11%	13.99%	11.64%	14.17%	12.90%	1.0018	12.93%	5,784,786
210061	Atlantic General Hospital	4.68%	6.69%	7.98%	7.84%	6.45%	7.15%	1.0018	7.16%	6,026,782
	STATE-WIDE	6.57%	6.68%	7.48%	7.71%	7.22%	7.47%	1.0018	7.48%	984,819,137

***** James Lawrence Kernan Hospital was excluded in the Regression Analysis***

Maryland Hospital Community Benefits Report
FY 2010

June 29, 2011

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Introduction

Each year, the Health Services Cost Review Commission ("Commission," or "HSCRC") collects community benefit information from individual hospitals to compile into a publicly-available statewide Community Benefit Report ("CBR"). This document contains summary information for all submitting Maryland hospitals for FY 2010. Individual hospital community benefit reports are available at the Commission's offices. Individual community benefit report data spreadsheets and reports will be available on the Commission's website in July 2011.

Background

Section 501(c)(3) of the Internal Revenue Service Code exempts organizations that are organized and operated exclusively for, among other things, religious, charitable, scientific, or educational purposes. As a result of their tax exempt status, nonprofit hospitals receive many benefits. They are generally exempted from federal income and unemployment taxes as well as from state and local income, property, and sales taxes. In addition, they have the ability to raise funds through tax-deductable donations and tax-exempt bond financing. Originally, the IRS permitted hospitals to qualify as "charitable" if they provided charity care to the extent of their financial ability to do so. However in 1969, Rev. Ruling 69-545 issued by the IRS broadened the meaning of "charitable" from charity care to the "promotion of health," stating:

> "[T]he promotion of health, like the relief of poverty and the advancement of education and religion, is one of the purposes in the general law of charity that is deemed beneficial to the community as a whole even though the class of beneficiaries eligible to receive a direct benefit from its activities does not include all members of the community, such as indigent members of the community, provided that the class is not so small that its relief is not of benefit to the community."

Thus was created the "community benefit standard" for hospitals to qualify for tax exempt status.

In March 2010, Congress passed the Patient Protection and Affordable Care Act ("ACA"). Under the ACA, every § 501(c)(3) hospital, whether independent or in a system, must conduct a community health needs assessment at least once every three years in order to maintain its tax-exempt status and avoid an annual penalty of up to $50,000. The first needs assessment will be due by the end of a hospital's fiscal year 2013 (by June 30, 2013 for a June 30 YE hospital). Each community health needs assessment must take into account input from persons who represent the broad interest of the community served, including those with special knowledge or expertise in public health, and the assessment must be made widely available to the public. An implementation strategy describing how a hospital will meet the community's health needs must be included, as well as a description of what the hospital has done historically to address its community needs. Furthermore, the hospital must identify any needs that have not

been met by the hospital and why these needs have not been addressed. This information will be reported on Schedule H of the IRS 990 forms.

The Maryland CBR process was enacted by the Maryland General Assembly in 2001 (Chapter 178 of the 2001 Laws of Maryland, and codified under Health-General Article §19-303 of the Maryland Annotated Code). The Maryland data reporting spreadsheet and instructions in their inception drew heavily on the experience of the Voluntary Hospitals of America ("VHA"), a nationwide network of community owned health care systems, which possessed over ten years of voluntary hospital community benefit reporting experience across many states. Since 2003, the Commission has worked with the Maryland Hospital Association and interested hospitals, local health departments, and health policy organizations and associations on the details, format, and updates to the community benefit report. The CBR process offers an opportunity for each Maryland acute care hospital to critically review and report its activities designed to benefit the community it serves. The first CBR (reporting FY 2004 experiences) was released in July 2005.

The Fiscal Year 2010 report represents the HSCRC's seventh year of reporting on Maryland hospital community benefit data.

Definition of Community Benefits:

Maryland law defines a "community benefit" as an activity that is intended to address community needs and priorities primarily through disease prevention and improvement of health status, including:

- Health services provided to vulnerable or underserved populations;
- Financial or in-kind support of public health programs;
- Donations of funds, property, or other resources that contribute to a community priority;
- Health care cost containment activities; and
- Health education screening and prevention services.

As evidenced in the individual reports, Maryland hospitals provide a broad range of health services to meet the needs of their communities, often receiving partial or no compensation. These activities, however, are expected from Maryland's 45 acute, not-for-profit hospitals as a result of the tax exemptions they receive. [1]

CBR – 2010 Highlights

The reporting period for this Community Benefit Report is July 1, 2009 – June 30, 2010. Hospitals submitted their individual community benefit reports to the HSCRC by December 15,

[1] Southern Maryland Hospital, the only for-profit hospital in Maryland, is not required to submit a community benefits report under the law. However, they have continued to submit a community benefit report to the HSCRC.

2010 using audited financial statements as the source for calculating costs in each of the care categories.

As shown in Table I below, Maryland hospitals provided approximately $1 billion dollars in total community benefit activities in FY 2010 (up from $946 million in FY 2009). This total is comprised of over $75.7 million in Community Health Services, more than $317 million in Health Professions Education, $255.7 million in Mission Driven Health Care Services, $6.6 million in Research activities, just over $15 million in Financial Contributions, $20.6 million in Community Building Activities, almost $5.5 million in Community Benefit Operations, and over $7 million in Foundation Funded Community Benefits.[2] Overall, Maryland hospitals reported providing just over $347 million in Charity Care.

Table I – Total Community Benefit

Community Benefit Category	Number of Staff Hours	Number of Encounters	Total Community Benefit
Community Health Services	922.648	8,225,443	$75,740,237
Health Professions Education	5,636,461	246,521	$317,353,507
Mission Driven Health Services	1,748,462	1,494,426	$255,756,006
Research	66,138	23,795	$6,633,123
Financial Contributions	38,872	159,751	$15,047,242
Community Building	188,093	361,453	$20,604,012
Community Benefit Operations	38,578	37,200	$5,457,144
Foundation	63,571	27,875	$7,026,417
Charity Care	n/a	n/a	$347,434,061
Total	8,702,821	10,594,464	$1,051,051,750

[2] These totals include hospital reported indirect costs, which vary by hospital and by category from a fixed dollar amount to a calculated percentage of the hospital's reported direct costs.

For additional detail and a description of subcategories under each community benefit category, please see the chart under Attachment I – Aggregated Hospital CBR Data.

Utilizing the data reported, Attachment II, FY 2010 CB Analysis, compares hospitals on the total amount of community benefits reported, the amount of community benefits that are recovered though HSCRC approved rates (charity care, direct medical education, and nurse support), the number of staff dedicated to community benefit operations, and information regarding hospitals' contact and/or use of local health departments in determining what needs will be addressed through community benefits activities. On average, in FY 2010, 839 hours were dedicated to Community Benefit ("CB") Operations. This is up by 65 hours from last year's average of 774 hours dedicated to CB Operations. Thirteen hospitals continue to report zero hours dedicated to CB Operations versus fourteen hospitals in FY 2009. The HSCRC continues to encourage hospitals to incorporate CB Operations into their strategic planning.

The total amount of community benefit dollars as a percentage of total operating expenses ranges from 1.29% to 17.09% with the average amount being 7.71%. This is up slightly from FY 2009's average of 7.6%. There are eight hospitals that report providing benefits in excess of 10% of their operating expenses, as compared to six in FY 2009. Four hospitals report spending less than 3% of their operating expenses on community benefit compared to seven hospitals last year.

In Maryland, the costs of uncompensated care (both charity care and bad debt) and graduate medical education are built into rates for which hospitals are reimbursed by all payers, including Medicare and Medicaid. Additionally, the HSCRC includes amounts in rates for hospital nurse support programs provided at Maryland hospitals. These costs are, in essence, "passed-through" to the purchasers and payers of hospital care. To avoid accounting confusion among programs that are not funded in part by hospital rate setting (unregulated), the HSCRC requested that hospitals <u>not</u> include revenue provided in rates as offsetting revenue on the CBR worksheet. Attachments III, IV, and V detail the amounts that are included in rates and funded by all payers for charity care, direct graduate medical education, and the nurse support program in Fiscal Year 2010.

As noted, the HSCRC includes a provision in hospital rates for uncompensated care; this includes charity care (eligible for inclusion as a community benefit by Maryland hospitals in their CBRs) and bad debt (not considered a community benefit). As shown in Attachment III, just under $214 million was provided in Maryland hospital rates in FY 2010 for the provision of charity care funded by all payers. When offset against the hospital reported amount of $347 million in charity care, the net amount provided by hospitals is $133 million.

Also as noted, another social cost funded in Maryland's rate-setting system is the cost of graduate medical education, generally for interns and residents trained in Maryland hospitals. Included in graduate medical education costs are the direct costs (Direct Medical Education or "DME"), which constitute wages and benefits of residents and interns, faculty supervisory expenses, and allocated overhead. The Commission utilizes its annual cost report to quantify the DME costs of physician training programs at Maryland hospitals. In FY 2010, these DME costs totaled $211.8 million. For further information about funding provided to specific hospitals, please see Attachment IV.

The Commission's Nurse Support Program I is aimed at addressing the short and long-term nursing shortage impacting Maryland hospitals. In FY 2010, over $11.6 million was provided in hospital rate adjustments. For further information about funding provided to specific hospitals, please see Attachment V.

When these costs are offset, the net community benefit provided by Maryland hospitals in FY 2010 was $ 613.5 million, or 4.85% of the total hospital operating expenses. This is up significantly from the $453 million in net benefits provided in FY 2009, which totaled approximately 3.64% of hospitals' operating expenses. Please see the chart in Attachment II for more detail.

In FY 2009, Hospitals were first asked to answer narrative questions that were developed, in part, to provide a standard reporting format for all hospitals. This uniformity not only provided readers of the individual hospital reports with more information than was previously available, but also allowed for comparisons across hospitals. The narrative guidelines were aligned, wherever possible, with the IRS form 990, schedule H, in an effort to provide as much consistency as is practical in reporting on the state and federal levels.

In addition to providing a standard format for reporting, the HSCRC considers the narrative guidelines to be a mechanism for assisting hospitals in critically examining their Community Benefit programs. Any examination of the effectiveness of major program initiatives may help hospitals determine which programs are achieving the desired results and which are not.

Along with the narrative reporting questions, a set of evaluation criteria were developed as an instrument to provide feedback to hospitals regarding their reports and the information contained therein. Out of a possible 100%, hospitals, on average, scored 96.93%. This tells us that an overwhelming majority of hospitals have provided the requested information sought through the narrative guidelines. However, scoring was based on whether a hospital answered each question, not necessarily whether appropriate detail was provided. In addition, 91.3% of hospitals report having had contact with their local health department in determining the needs of

their community, while 8.7% either did not contact their local health department, or did not report contacting their local health department as a component of their needs assessment process.

Changes to the FY 2011 Reporting Requirements

The national community benefit landscape continues to evolve, especially with the related provisions of the ACA. Each year the Commission refines its reporting requirements and takes into account state and federal law, and regulatory changes related to community benefits. To this end, the HSCRC convened an advisory group from November 2010 to May 2011. The advisory group consisted of representatives from HSCRC staff, the Department of Health and Mental Hygiene, local health departments, health policy organizations, the Maryland Hospital Association, and Maryland hospitals. The hospital representatives are responsible for conducting hospital community benefit activities within their respective hospitals.

Based on input from the advisory group, the HSCRC is making changes to the FY 2011 Community Benefit Reporting Guidelines and Standard Definitions as well as to the Community Benefits Narrative Reporting Instructions and related Evaluation. The following changes were made to the Reporting Guidelines:

- Refinement of the definition of a community benefit, consistent with ACA and other policies;
- Clarification of what is included or excluded in various categories based on inquiries; and
- Addition of a section to account for Medicaid provider taxes for which a hospital does not receive offsetting revenue.

Changes to the Community Benefit Narrative Reporting Instructions and the related Evaluation Report include:

- Refining the definition of a community needs assessment;
- Altering the format and providing more references to make it easier for hospitals to meet the HSCRC's expectations for reporting, and for the public to read and understand the reports;
- Adding questions to better understand who is involved with community benefit operations, and who is being consulted on community needs assessments; and
- Making most of the evaluation scoring based on the sufficiency of hospitals' responses to narrative reporting questions.

The HSCRC will continue in its efforts to evaluate the reporting process and make changes where necessary to encourage hospitals in their mission to serve the public, in part, by identifying and working to provide programs that will meet the growing health needs of the communities they serve.

Attachment I – FY 2010 CB Aggregate Data

FY 2010 Maryland Hospital Community Benefit Totals

	A Community Health Services	# of Staff Hours	# of Encounters	Direct Cost ($)	Indirect Cost ($)	Offsetting Revenue	Net Community Benefit W/Indirect Cost	Net Community Benefit W/O Indirect Cost
A1	Community Health Education	316,797	7,342,615	$18,746,597	$10,162,417	$2,844,606	$26,064,408	$15,901,991
	Support Groups	15,229	41,348	$858,557	$439,648	$43,835	$1,254,371	$814,722
	Self-Help	23,251	73,479	$1,146,018	$578,506	$392,948	$1,331,576	$753,070
A2	Community-Based Clinical Services	316,714	285,352	$12,099,598	$3,033,788	$1,486,028	$13,647,358	$10,613,570
	Screenings	26,846	65,995	$2,996,952	$1,715,858	$236,564	$4,476,246	$2,760,388
	One-Time/Occassionally Held Clinics	1,686	16,224	$170,834	$89,184	$185,844	$74,174	($15,010)
	Free Clinics	1,716	5,785	$757,190	$424,481	$261,276	$920,395	$495,914
	Mobile Units	19,987	17,000	$362,758	$175,575	$0	$538,333	$362,758
A3	Health Care Support Services	154,662	249,696	$15,290,275	$7,815,034	$2,272,575	$20,832,734	$13,017,700
A4	Other	45,758	127,949	$4,412,999	$2,224,462	$36,818	$6,600,644	$4,376,181
	totals	**922,648**	**8,225,443**	**$56,841,779**	**$26,658,954**	**$7,760,495**	**$75,740,237**	**$49,081,284**

	B Health Professions Education	# of Staff Hours	# of Encounters	Direct Cost ($)	Indirect Cost ($)	Offsetting Revenue	Net Community Benefit W/Indirect Cost	Net Community Benefit W/O Indirect Cost
B1	Physicians/Medical Students	4,976,799	26,505	$219,961,106	$61,837,140	$1,376,916	$280,421,329	$218,584,190
B2	Scholarships/Funding for Professional Education	9,805	1,745	$2,851,556	$276,411	$138,161	$2,989,807	$2,713,395
B3	Nurses/Nursing Students	379,632	89,207	$16,074,616	$5,960,941	$486,473	$21,549,083	$15,588,143
B4	Technicians	77,833	51,844	$2,792,492	$1,212,978	$164,207	$3,841,263	$2,628,285
B5	Other Health Professionals	155,930	81,653	$5,971,728	$1,083,264	$30,000	$7,024,992	$5,941,728
B6	Other	36,463	13,568	$1,311,673	$309,232	$93,873	$1,527,033	$1,217,800
	Totals	**5,636,461**	**264,521**	**$248,963,171**	**$70,679,967**	**$2,289,630**	**$317,353,507**	**$246,673,541**

	C Mission Driven Health Services	# of Staff Hours	# of Encounters	Direct Cost ($)	Indirect Cost ($)	Offsetting Revenue	Net Community Benefit W/Indirect Cost	Net Community Benefit W/O Indirect Cost
		1,748,462	**1,494,426**	**$310,919,538**	**$79,700,240**	**$134,863,772**	**$255,756,006**	**$176,055,766**

	D Research	# of Staff Hours	# of Encounters	Direct Cost ($)	Indirect Cost ($)	Offsetting Revenue	Net Community Benefit W/Indirect Cost	Net Community Benefit W/O Indirect Cost
D1	Clinical	59,852	23,691	$5,786,780	$2,514,289	$2,213,643	$6,087,426	$3,573,137
D2	Community Health Research	15	36	$76,153	$348	$0	$76,501	$76,153
D3	Other	6,271	68	$310,170	$159,026	$0	$469,196	$310,170
	Totals	**66,138**	**23,795**	**$6,173,103**	**$2,673,663**	**$2,213,643**	**$6,633,123**	**$3,959,460**

	E Financial Contributions	# of Staff Hours	# of Encounters	Direct Cost ($)	Indirect Cost ($)	Offsetting Revenue	Net Community Benefit W/Indirect Cost	Net Community Benefit W/O Indirect Cost
E1	Cash Donations	1,993	8,194	$6,894,178	$1,122,586	$182,083	$7,834,681	$6,712,095
E2	Grants	30	24	$361,592	$0	$208,860	$152,732	$152,732
E3	In-Kind Donations	34,927	120,306	$3,613,601	$342,440	$88,193	$3,867,847	$3,525,408
E4	Cost of Fund Raising for Community Programs	1,923	31,227	$511,920	$87,134	$0	$599,054	$511,920
E5	Sales Taxes, Property Taxes, Income Taxes*	0	0	$2,592,928	$0	$0	$2,592,928	$2,592,928
	Totals	**38,872**	**159,751**	**$13,974,219**	**$1,552,160**	**$479,136**	**$15,047,242**	**$13,495,083**

FY 2010 Maryland Hospital Community Benefit Totals

F	Community Building Activities	# of Staff Hours	# of Encounters	Direct Cost ($)	Indirect Cost ($)	Offsetting Revenue	Net Community Benefit W/Indirect Cost	Net Community Benefit W/O Indirect Cost
F1	Physical Improvements/Housing	8,958	186,630	$4,589,161	$902,195	$2,328,011	$3,163,345	$2,261,150
F2	Economic Development	18,277	15,200	$1,531,515	$822,207	$457,388	$1,896,334	$1,074,127
F3	Support System Enhancements	38,247	31,980	$2,787,089	$1,329,023	$354,708	$3,761,404	$2,432,381
F4	Environmental Improvements	11,544	579	$403,890	$206,524	$0	$610,415	$403,890
F5	Leadership Development/Training for Community Members	20,497	3,916	$432,294	$225,704	$0	$657,998	$432,294
F6	Coalition Building	7,479	20,601	$474,020	$264,667	$150	$738,537	$473,870
F7	Community Health Improvement Advocacy	10,222	18,771	$1,439,364	$751,575	$12,000	$2,178,939	$1,427,364
F8	Workforce Enhancement	32,602	28,297	$3,164,805	$1,465,046	$199,266	$4,430,585	$2,965,539
F9	Other	40,269	55,479	$2,181,486	$1,004,745	$19,777	$3,166,455	$2,161,709
	Totals	**188,093**	**361,453**	**$17,003,625**	**$6,971,687**	**$3,371,300**	**$20,604,012**	**$13,632,325**

G	Community Benefit Operations	# of Staff Hours	# of Encounters	Direct Cost ($)	Indirect Cost ($)	Offsetting Revenue	Net Community Benefit W/Indirect Cost	Net Community Benefit W/O Indirect Cost
G1	Dedicated Staff	28,467	19,201	$1,655,531	$945,564	$10,850	$2,590,245	$1,644,681
G2	Community Health/Health Assets Assessments	1,626	1,409	$105,120	$49,759	$0	$154,879	$105,120
G3	Other Resources	8,484	16,590	$1,669,002	$1,046,451	$3,433	$2,712,019	$1,665,569
	Totals	**38,578**	**37,200**	**$3,429,653**	**$2,041,774**	**$14,283**	**$5,457,144**	**$3,415,370**

H	Charity Care (report total only)	
		$347,434,061

J	FOUNDATION COMMUNITY BENEFIT	# of Staff Hours	# of Encounters	Direct Cost ($)	Indirect Cost ($)	Offsetting Revenue	Net Community Benefit W/Indirect Cost	Net Community Benefit W/O Indirect Cost
J1	Community Services	16,158	5,105	$3,446,385	$1,364,752	$3,756	$4,807,381	$3,442,629
J2	Community Building	47,413	22,763	$1,866,797	$291,712	$0	$2,158,509	$1,866,797
J3	Other (Please indicate below):	0	7	$55,617	$4,910	$0	$60,527	$55,617
	Totals	**63,571**	**27,875**	**$5,368,799**	**$1,661,374**	**$3,756**	**$7,026,417**	**$5,365,043**

K	Total Hospital Community Benefit	# of Staff Hours	# of Encounters	Direct Cost ($)	Indirect Cost ($)	Offsetting Revenue	Net Community Benefit W/Indirect Cost	Net Community Benefit W/O Indirect Cost
A	Community Health Services	**922,648**	**8,225,443**	**$56,841,779**	**$26,658,954**	**$7,760,495**	**$75,740,237**	**$49,081,284**
B	Health Professions Education	**5,636,461**	**264,521**	**$248,963,171**	**$70,679,967**	**$2,289,630**	**$317,353,507**	**$246,673,541**
C	Mission Driven Health Care Services	**1,748,462**	**1,494,426**	**$310,919,538**	**$79,700,240**	**$134,863,772**	**$255,756,006**	**$176,055,766**
D	Research	**66,138**	**23,795**	**$6,173,103**	**$2,673,663**	**$2,213,643**	**$6,633,123**	**$3,959,460**
E	Finanical Contributions	**38,872**	**159,751**	**$13,974,219**	**$1,552,160**	**$479,136**	**$15,047,242**	**$13,495,083**
F	Community Building Activities	**188,093**	**361,453**	**$17,003,625**	**$6,971,687**	**$3,371,300**	**$20,604,012**	**$13,632,325**
G	Community Benefit Operations	**38,578**	**37,200**	**$3,429,653**	**$2,041,774**	**$14,283**	**$5,457,144**	**$3,415,370**
H	Charity Care	**0**	**0**	**$347,434,061**	**$0**	**$0**	**$347,434,061**	**$347,434,061**
J	Foundation Funded Community Benefit	**63,571**	**27,875**	**$5,368,799**	**$1,661,374**	**$3,756**	**$7,026,417**	**$5,365,043**
	Total Hospital Community Benefits	**8,702,821**	**10,594,464**	**$1,010,107,947**	**$191,939,818**	**$150,996,015**	**$1,051,051,750**	**$859,111,932**

TOTAL OPERATING EXPENSE	**$12,647,785,379**
% OF OPERATING EXPENSES W/IC	**8.31%**
% OF OPERATING EXPENSES W/O IC	**6.79%**

Attachment II – FY 2010 CB Analysis

FY 2010 CB Analysis

hospid	Hospital Name	Employees	Total Staff Hours CB Operations	Total Hospital Operating Expense	Total Community Benefit	Total CB as % of Total Operating Expense	FY 2010 Amount in Rates for Charity Care, DME, and NSPI	Total Net CB minus Charity Care, DME, NSPI in Rates	Total Net CB(minus charity Care, DME, NSPI in Rates) as % of Operating Expense	CB Reported Charity Care	Reported Contact with Local Health Department	Score Card	
23	Anne Arundel	3443	250	$409,878,000	$14,840,493	3.62%	$3,644,734	$11,195,759	2.73%	$5,610,268	yes	100.00%	
61	Atlantic General	698*	444	$85,576,479	$5,009,184	5.85%	$592,163	$4,417,021	5.16%	$1,729,056	yes	100.00%	
43	Baltimore Washington	2600	80	$286,527,529	$8,638,371	3.01%	$3,989,120	$4,649,251	1.62%	$4,979,531	yes	100.00%	
13	Bon Secours	787	0	$134,275,363	$18,998,359	14.15%	$5,377,206	$13,621,153	10.14%	$9,646,381	yes	90.00%	
39	Calvert Memorial	1100	280	$124,624,087	$10,204,379	8.19%	$966,057	$9,238,323	7.41%	$2,021,139	yes	100.00%	
33	Carroll Hospital	1750	6,129	$189,995,760	$21,475,821	11.30%	$4,202,768	$17,273,052	9.09%	$4,992,380	yes	100.00%	
30	Chester River	471	0	$57,534,000	$5,589,431	9.72%	$1,034,762	$4,554,668	7.92%	$2,771,833	yes	100.00%	
35	Civista	826	3,898	$102,089,042	$4,414,688	4.32%	$1,260,354	$3,154,335	3.09%	$1,841,767	yes	95.00%	
51	Doctors	1298	80	$183,636,478	$3,916,189	2.13%	$798,832	$3,117,357	1.70%	$923,563	no	90.00%	
60	Fort Washington	446*	0	$43,015,368	$946,512	2.20%	$307,393	$639,119	1.49%	$634,221	yes	60.00%	
15	Franklin Square	3334	3,975	$383,921,400	$30,692,230	7.99%	$16,431,560	$14,260,670	3.71%	$8,924,317	yes	100.00%	
5	Frederick Memorial	2042	0	$303,496,000	$16,967,148	5.59%	$2,590,824	$14,376,324	4.74%	$4,062,500	yes	91.00%	
17	Garrett County	311	164	$34,581,479	$2,459,292	7.11%	$699,779	$1,759,513	5.09%	$2,259,121	yes	100.00%	
44	GBMC	3000	148	$381,690,221	$16,384,670	4.29%	$7,573,846	$8,810,824	2.31%	$5,126,284	yes	100.00%	
2004	Good Samaritan	2434	2,254	$294,051,000	$19,947,617	6.78%	$8,711,325	$11,236,292	3.82%	$5,884,000	yes	100.00%	
34	Harbor Hospital	1397	88	$183,722,000	$18,414,744	10.02%	$9,299,370	$9,115,374	4.96%	$6,205,500	yes	100.00%	
4	Holy Cross	3578	5,509	$371,919,817	$37,066,628	9.97%	$11,073,891	$25,992,737	6.99%	$16,429,743	yes	100.00%	
48	Howard County	1734	265	$222,150,000	$15,005,334	6.75%	$2,540,854	$12,464,480	5.61%	$3,997,000	yes	100.00%	
29	JH Bayview	3475	437	$504,651,000	$49,919,271	9.89%	$30,640,018	$19,279,253	3.82%	$21,740,000	yes	100.00%	
9	Johns Hopkins	9600	3,633	$1,586,616,331	$135,942,167	8.57%	$96,703,993	$39,238,175	2.47%	$36,059,669	yes	100.00%	
2001	Kernan	680	960	$91,563,920	$6,286,847	6.87%	$3,387,504	$2,899,342	3.17%	$644,000	no	95.00%	
55	Laurel Regional	519	61	$92,314,100	$15,171,974	16.44%	$3,202,533	$11,969,441	12.97%	$5,741,000	no	70.00%	
38	Maryland General	1020	552	$176,676,019	$12,145,578	6.87%	$9,887,525	$2,258,053	1.28%	$6,798,000	no	100.00%	
45	McCready	303	48	$16,245,226	$1,183,757	7.29%	$174,298	$1,009,460	6.21%	$919,829	yes	90.00%	
8	Mercy	2934	200	$351,060,000	$43,005,420	12.25%	$9,685,881	$33,319,539	9.49%	$10,870,164	yes	100.00%	
18	Montgomery General	1340*	105	$125,528,600	$10,076,770	8.03%	$3,746,088	$6,330,682	5.04%	$5,883,000	yes	100.00%	
40	Northwest	1550	0	$196,487,000	$13,215,519	6.73%	$2,017,364	$11,198,155	5.70%	$3,380,000	yes	100.00%	
19	Peninsula	2662	127	$363,438,000	$16,196,630	4.46%	$4,445,642	$11,750,988	3.23%	$7,958,800	yes	85.00%	
3	Prince George's	1478	61	$245,390,100	$41,939,862	17.09%	$14,995,029	$26,944,833	10.98%	$17,794,506	yes	100.00%	
5050	Shady Grove	2091	1,243	$292,443,551	$27,107,722	9.27%	$7,195,115	$19,912,606	6.81%	$7,910,344	yes	100.00%	
37	Shore Health - Easton	1290*	0	$133,188,248	$9,799,329	7.36%	$1,846,720	$7,952,609	5.97%	$3,797,021	yes	100.00%	
10	Shore Health -Dorchester	643	0	$42,143,033	$3,017,828	7.16%	$658,153	$2,359,675	5.60%	$602,876	yes	100.00%	
12	Sinai	4345	2,810	$650,959,000	$58,070,301	8.92%	$24,076,875	$33,993,426	5.22%	$12,459,755	yes	100.00%	
54	Southern Maryland	1636	0	$215,067,531	$16,909,732	7.86%	$2,161,874	$14,747,858	6.86%	$1,764,265	yes	80.00%	
11	St. Agnes	2523	0	$362,895,665	$31,847,338	8.78%	$16,326,297	$15,521,041	4.28%	$15,669,272	yes	100.00%	
7	St. Joseph	2224	0	$340,681,712	$4,405,696	1.29%	$1,749,830	$2,655,866	0.78%	$3,482,673	yes	93.00%	
28	St. Mary's	1062	147	$107,888,100	$8,198,174	7.60%	$1,964,692	$6,233,482	5.78%	$3,924,500	yes	100.00%	
22	Suburban	1400	1,420	$231,909,000	$18,566,759	8.01%	$3,372,734	$15,194,024	6.55%	$4,300,000	yes	100.00%	
6	UCH-Harford	793	0	$86,966,000	$4,334,022	4.98%	$797,548	$3,536,474	4.07%	$1,439,219	yes	100.00%	
49	UCH-Upper Chesapeake	1724*	0	$190,257,000	$7,005,675	3.68%	$1,419,713	$5,585,962	2.94%	$2,213,558	yes	100.00%	
32	Union Cecil County	1018	227	$132,709,275	$3,101,188	2.34%	$563,928	$2,537,260	1.91%	$1,315,553	yes	100.00%	
24	Union Memorial	2528	75	$384,174,900	$34,318,107	8.93%	$22,043,371	$12,274,736	3.20%	$11,236,600	yes	95.00%	
2	University of Maryland	5937*	1,379	$1,164,113,000	$159,212,948	13.68%	$77,360,767	$81,852,182	7.03%	$46,227,000	yes	100.00%	
16	Washington Adventist	1580	1,271	$250,317,331	$36,333,827	14.52%	$7,327,741	$29,006,086	11.59%	$8,567,128	yes	100.00%	
1	Washington Co (Meritus)	2095	258	$243,735,000	$21,499,745	8.82%	$5,177,287	$16,322,458	6.70%	$10,909,573	yes	100.00%	
27	Western MD Regional	2280	0	$275,682,715	$11,268,469	4.09%	$3,465,946	$7,802,523	2.83%	$5,787,152	yes	100.00%	
	Totals	**80,544**	**38,577**	**$12,647,785,380**	**$1,051,051,746**	**8.31%**	**$437,489,304**	**$613,562,442**	**4.85%**	**$347,434,061**			
											yes= 91.30%		
	Averages	**2,014**	**839**			**7.71%**			**5.22%**		**no = 8.70%**	**96.39%**	
		*** The hospital did not provide the number of employees in its FY 2010 CB report,**											
		therefore the number reported is from the FY 2009 report.											

Attachment III – FY 2010 Charity Care Funding

Hospital Name	Charity Care Amount in Rates
Anne Arundel General Hospital	$3,283,394
Atlantic General Hospital	$518,728
Baltimore Washington Medical Center	$3,388,280
Bon Secours Hospital	$5,279,949
Calvert Memorial Hospital	$863,711
Carroll County General Hospital	$4,016,506
Chester River Hospital Center	$979,322
Civista Medical Center	$1,160,290
Doctors Community Hospital	$624,359
Fort Washington Medical Center	$259,809
Franklin Square Hospital	$7,799,791
Frederick Memorial Hospital	$2,346,006
Garrett County Memorial Hospital	$666,926
GBMC	$2,682,646
Good Samaritan Hospital	$3,632,214
Harbor Hospital Center	$5,174,966
Holy Cross Hospital of Silver Spring	$8,427,895
Howard County General Hospital	$2,353,642
JH Bayview Med. Center	$11,835,857
Johns Hopkins Hospital	$22,487,372
Kernan	$231,311
Laurel Regional Hospital	$3,109,383
Maryland General Hospital	$5,692,593
McCready Foundation, Inc.	$157,212
Mercy Medical Center, Inc.	$5,127,841
Montgomery General Hospital	$3,611,653
Northwest Hospital Center, Inc.	$1,816,159
Peninsula Regional Medical Center	$4,295,642
Prince Georges Hospital	$11,247,701
Shady Grove Adventist Hospital	$6,890,765
Shore Health - Easton	$1,702,608
Shore Health-Dorchester General Hospital	$610,157
Sinai Hospital	$10,313,438
Southern Maryland Hospital	$1,935,300
St. Agnes Hospital	$9,270,742
St. Josephs Hospital	$1,386,020
St. Mary's Hospital	$1,850,040
Suburban Hospital	$2,958,257
UCH - Harford Memorial Hospital	$699,259
UCH - Upper Chesapeake Medical Center	$1,222,814
Union Hospital of Cecil County	$469,328
Union Memorial Hospital	$9,442,378
University of Maryland	$26,733,143
Washington Adventist Hospital	$7,048,323
Washington County Hospital (Meritus)	$4,955,619
Western Maryland Regional Medical Center	$3,390,225
Anne Arundel General Hospital	$3,283,394
Total	$213,949,574

Attachment IV - FY 2010 DME Funding

Hospital Name	DME Amount in Rates
Anne Arundel	0
Atlantic General	0
Baltimore Washington	$316,600
Bon Secours	0
Calvert Memorial	0
Carroll Hospital	0
Chester River	0
Civista	0
Doctors	0
Fort Washington	0
Franklin Square	$8,230,100
Frederick Memorial	0
Garrett County	0
GBMC	$4,541,200
Good Samaritan	$4,813,700
Harbor Hospital	$4,015,400
Holy Cross	$2,365,900
Howard County	0
JH Bayview	$18,311,300
Johns Hopkins	$72,684,100
Kernan	$3,058,900
Laurel Regional	0
Maryland General	$4,014,300
McCready	0
Mercy	$4,204,800
Montgomery General	0
Northwest	0
Peninsula	0
Prince George's	$3,505,400
Saint Agnes	$6,722,000
Saint Joseph	0
Saint Mary's	0
Shady Grove	0
Shore Health - Easton	0
Shore Health -Dorchester	0
Sinai	$13,161,100
Southern Maryland	0
Suburban	$193,500
UCH-Harford	0
UCH-Upper Chesapeake	0
Union Cecil County	0
Union Memorial	$12,187,600
University of Maryland	$49,537,800
Washington Adventist	0
Washington County Hospital (Meritus)	0
Western Maryland Regional Medical Center	0
Total	$211,863,700

Attachment V - FY 2010 Nurse Support I Funding

Hospital Name	NSP I Amount in Rates
Anne Arundel	$361,340
Atlantic General	$73,435
Baltimore Washington	$284,240
Bon Secours	$97,257
Calvert Memorial	$102,346
Carroll Hospital	$186,262
Chester River	$55,440
Civista	$100,064
Doctors	$174,473
Fort Washington	$47,584
Franklin Square	$401,669
Frederick Memorial	$244,818
Garrett County	$32,853
GBMC	$350,000
Good Samaritan	$265,411
Harbor Hospital	$109,004
Holy Cross	$280,096
Howard County	$187,212
JH Bayview	$492,861
Johns Hopkins	$1,532,521
Kernan	$97,293
Laurel Regional	$93,150
Maryland General	$180,632
McCready	$17,086
Mercy	$353,240
Montgomery General	$134,435
Northwest	$201,205
Peninsula	$150,000
Prince George's	$241,928
Saint Agnes	$333,555
Saint Joseph	$363,810
Saint Mary's	$114,652
Shady Grove	$304,350
Shore Health - Easton	$144,112
Shore Health -Dorchester	$47,996
Sinai	$602,337
Southern Maryland	$226,574
Suburban	$220,977
UCH-Harford	$98,289
UCH-Upper Chesapeake	$196,899
Union Cecil County	$94,600
Union Memorial	$413,393
University of Maryland	$1,089,824
Washington Adventist	$279,418
Washington County Hospital (Meritus)	$221,668
Western Maryland Regional Medical Center	$75,721
Total	$11,676,030

FY 2011 Community Benefit Reporting Template

June 29, 2011

	A	B	C	D	E	F	G	H	I	J	K	L
1												
2						**FY 2011 COMMUNITY BENEFIT INVENTORY SPREADSHEET**							
3		**GENERAL INFORMATION**										
4												
5		**Hospital Name:**										
6		**HSCRC Hospital ID #:**										
7		**# of Employees:**										
8												
9		**Contact Person:**										
10		**Contact Number:**										
11		**Contact Email:**										
12												
13												
14												
15												
16		**UNREIMBURSED MEDICAID COST**				**# OF STAFF HOURS**	**# OF ENCOUNTERS**	**DIRECT COST($)**	**INDIRECT COST($)**	**OFFSETTING REVENUE($)**	**NET COMMUNITY BENEFIT**	
17	**T00**	**Medicaid Costs**										
18	**T99**	Medicaid Assessments				N/A	N/A		$0.00		$0.00	
19		**COMMUNITY BENEFIT ACTIVITES**				**# OF STAFF HOURS**	**# OF ENCOUNTERS**	**DIRECT COST($)**	**INDIRECT COST($)**	**OFFSETTING REVENUE($)**	**NET COMMUNITY BENEFIT**	
20	**A00.**	**COMMUNITY HEALTH SERVICES**										
21	**A10**	Community Health Education							$0.00		$0.00	
22	**A11**	Support Groups							$0.00		$0.00	
23	**A12**	Self-Help							$0.00		$0.00	
24	**A20**	Community-Based Clinical Services							$0.00		$0.00	
25	**A21**	Screenings							$0.00		$0.00	
26	**A22**	One-Time/Occasionally Held Clinics							$0.00		$0.00	
27	**A23**	Free Clinics							$0.00		$0.00	
28	**A24**	Mobile Units							$0.00		$0.00	
29	**A30**	Health Care Support Services							$0.00		$0.00	
30	**A40**								$0.00		$0.00	
31	**A41**								$0.00		$0.00	
32	**A42**								$0.00		$0.00	
33	**A43**								$0.00		$0.00	
34	**A44**								$0.00		$0.00	
35												
36	**A99**	**Total Community Health Services**			**TOTAL**	0	0	0	$0.00	$0.00	$0.00	
37												

	A	B	C	D	E	F	G	H	I	J	K	L
38						# OF STAFF HOURS	# OF ENCOUNTERS	DIRECT COST($)	INDIRECT COST($)	OFFSETTING REVENUE($)	NET COMMUNITY BENEFIT	
39	**B00**	**HEALTH PROFESSIONS EDUCATION**										
40	**B10**	Physicians/Medical Students							$0.00		$0.00	
41	**B20**	Nurses/Nursing Students							$0.00		$0.00	
42	**B30**	Other Health Professionals							$0.00		$0.00	
43	**B40**	Scholarships/Funding for Professional Education							$0.00		$0.00	
44	**B50**								$0.00		$0.00	
45	**B51**								$0.00		$0.00	
46	**B52**								$0.00		$0.00	
47	**B53**								$0.00		$0.00	
48												
49	**B99**	**Total Health Professions Education**			**TOTAL**	0	0	$0.00	$0.00	$0.00	$0.00	
50												
51						# OF STAFF HOURS	# OF ENCOUNTERS	DIRECT COST($)	INDIRECT COST($)	OFFSETTING REVENUE($)	NET COMMUNITY BENEFIT	
52	**C00**	**MISSION DRIVEN HEALTH SERVICES (please list)**										
53	**C10**								$0.00		$0.00	
54	**C20**								$0.00		$0.00	
55	**C30**								$0.00		$0.00	
56	**C40**								$0.00		$0.00	
57	**C50**								$0.00		$0.00	
58	**C60**								$0.00		$0.00	
59	**C70**								$0.00		$0.00	
60	**C80**								$0.00		$0.00	
61	**C90**								$0.00		$0.00	
62	**C91**								$0.00		$0.00	
63												
64	**C99**	**Total Mission Driven Health Services**			**TOTAL**	0	0	$0.00	$0.00	$0.00	$0.00	
65												
66						# OF STAFF HOURS	# OF ENCOUNTERS	DIRECT COST($)	INDIRECT COST($)	OFFSETTING REVENUE($)	NET COMMUNITY BENEFIT	
67	**D00**	**RESEARCH**										
68	**D10**	Clinical Research							$0.00		$0.00	
69	**D20**	Community Health Research							$0.00		$0.00	
70	**D30**								$0.00		$0.00	
71	**D31**								$0.00		$0.00	
72	**D32**								$0.00		$0.00	
73												
74	**D99**	**Total Research**			**TOTAL**	0	0	0	$0.00	0	$0.00	

	A	B	C	D	E	F	G	H	I	J	K	L
75						# OF STAFF HOURS	# OF ENCOUNTERS	DIRECT COST($)	INDIRECT COST($)	OFFSETTING REVENUE($)	NET COMMUNITY BENEFIT	
76	**E00**	**Cash and In-Kind Contributions**										
77	**E10**	Cash Donations							$0.00		$0.00	
78	**E20**	Grants							$0.00		$0.00	
79	**E30**	In-Kind Donations							$0.00		$0.00	
80	**E40**	Cost of Fund Raising for Community Programs							$0.00		$0.00	
81												
82	**E99**	**Total Cash and In-Kind Contributions**			**TOTAL**	0	0	$0.00	$0.00	$0.00	$0.00	
83												
84						# OF STAFF HOURS	# OF ENCOUNTERS	DIRECT COST($)	INDIRECT COST($)	OFFSETTING REVENUE($)	NET COMMUNITY BENEFIT	
85	**F00**	**COMMUNITY BUILDING ACTIVITIES**										
86	**F10**	Physical Improvements and Housing							$0.00		$0.00	
87	**F20**	Economic Development							$0.00		$0.00	
88	**F30**	Community Support							$0.00		$0.00	
89	**F40**	Environmental Improvements							$0.00		$0.00	
90	**F50**	Leadership Development/Training for Community Members							$0.00		$0.00	
91	**F60**	Coalition Building							$0.00		$0.00	
92	**F70**	Advocacy for Community Health Improvements							$0.00		$0.00	
93	**F80**	Workforce Development							$0.00		$0.00	
94	**F90**								$0.00		$0.00	
95	**F91**								$0.00		$0.00	
96	**F92**								$0.00		$0.00	
97												
98	**F99**	**Total Community Building Activities**			**TOTAL**	0	0	0	0	0	0	
99												
100						# OF STAFF HOURS	# OF ENCOUNTERS	DIRECT COST($)	INDIRECT COST($)	OFFSETTING REVENUE($)	NET COMMUNITY BENEFIT	
101	**G00**	**COMMUNITY BENEFIT OPERATIONS**										
102	**G10**	Assigned Staff							$0.00		$0.00	
103	**G20**	Community health/health assets assessments							$0.00		$0.00	
104	**G30**								$0.00		$0.00	
105	**G31**								$0.00		$0.00	
106	**G32**								$0.00		$0.00	
107												
108	**G99**	**Total Community Benefit Operations**			**TOTAL**	0	0	$0.00	$0.00	$0.00	$0.00	
109												

	A	B	C	D	E	F	G	H	I	J	K	L
110	**H00**	**CHARITY CARE (report total only)**										
111	**H99**	**Total Charity Care**			**TOTAL**							
112												
113		**FINANCIAL DATA**										
114	**I10**	INDIRECT COST RATIO										
115												
116	**I00**	**OPERATING REVENUE**										
117	**I20**	Net Patient Service Revenue										
118	**I30**	Other Revenue										
119	**I40**	**Total Revenue**				$0.00						
120												
121	**S99**	**TOTAL OPERATING EXPENSES**										
122												
123	**I50**	**NET REVENUE (LOSS) FROM OPERATIONS**										
124												
125	**I60**	**NON-OPERATING GAINS (LOSSES)**										
126												
127	**I70**	**NET REVENUE (LOSS)**										
128												
129						**# OF STAFF HOURS**	**# OF ENCOUNTERS**	**DIRECT COST($)**	**INDIRECT COST($)**	**OFFSETTING REVENUE($)**	**NET COMMUNITY BENEFIT**	
130	**J00**	**FOUNDATION COMMUNITY BENEFIT**										
131	**J10**	Community Services							$0.00		$0.00	
132	**J20**	Community Building							$0.00		$0.00	
133	**J30**								$0.00		$0.00	
134	**J31**								$0.00		$0.00	
135	**J32**								$0.00		$0.00	
136												
137	**J99**	**TOTAL FOUNDATION COMMUNITY BENEFIT**				0	0	$0.00	$0.00	$0.00	$0.00	
138												

	A	B	C	D	E	F	G	H	I	J	K	L
139						# OF STAFF HOURS	# OF ENCOUNTERS	DIRECT COST($)	INDIRECT COST($)	OFFSETTING REVENUE($)	NET COMMUNITY BENEFIT	
140	K00	TOTAL HOSPITAL COMMUNITY BENEFIT										
141	A99	Community Health Services				0	0	0	0	0	0	
142	B99	Health Professions Education				0	0	0	0	0	0	
143	C99	Mission Driven Health Care Services				0	0	0	0	0	0	
144	D99	Research				0	0	0	0	0	0	
145	E99	Financial Contributions				0	0	0	0	0	0	
146	F99	Community Building Activities				0	0	0	0	0	0	
147	G99	Community Benefit Operations				0	0	0	0	0	0	
148	H99	Charity Care				N/A	N/A	N/A	N/A	N/A	$0.00	
149	J99	Foundation Funded Community Benefit				0	0	0	0	0	0	
150	T99	Medicaid Assesments				N/A	N/A	0	0	0	0	
151												
152	K99	TOTAL HOSPITAL COMMUNITY BENEFIT				0	0	0	0	0	0	
153												
154	U99	% OF OPERATING EXPENSES				#DIV/0!						
155	V99	% of NET REVENUE				#DIV/0!						
156												

COMMUNITY BENEFIT NARRATIVE REPORTING INSTRUCTIONS

Effective for FY2011 Community Benefit Reporting

Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore MD 21215

BACKGROUND

The Health Services Cost Review Commission's (HSCRC or Commission) Community Benefit Report, required under §19-303 of the Health General Article, Maryland Annotated Code, is the Commission's method of implementing a law that addresses the growing interest in understanding the types and scope of community benefit activities conducted by Maryland's nonprofit hospitals.

The Commission's response to its mandate to oversee the legislation was to establish a reporting system for hospitals to report their community benefits activities. The guidelines and inventory spreadsheet were guided, in part, by the VHA, CHA, and others' community benefit reporting experience, and was then tailored to fit Maryland's unique regulated environment. The narrative requirement is intended to strengthen and supplement the qualitative and quantitative information that hospitals have reported in the past. The narrative is focused on (1) the general demographics of the hospital community, (2) how hospitals determined the needs of the communities they serve, and (3) hospital community benefit administration.

Reporting Requirements

I. GENERAL HOSPITAL DEMOGRAPHICS AND CHARACTERISTICS:

1. Please list the following information in Table I below. For the purposes of this section, "primary services area" means the Maryland postal ZIP code areas from which the first 60 percent of a hospital's patient discharges originate during the most recent 12 month period available, where the discharges from each ZIP code are ordered from largest to smallest number of discharges. This information will be provided to all hospitals by the HSCRC.

Table I

Bed Designation:	Inpatient Admissions:	Primary Service Area Zip Codes:	All other Maryland Hospitals Sharing Primary Service Area:	Percentage of Uninsured Patients, by County:	Percentage of Patients who are Medicaid Recipients, by County:

2. For purposes of reporting on your community benefit activities, please provide the following information:

   a. Describe in detail the community or communities the organization serves. (For the purposes of the questions below, this will be considered the hospital's Community Benefit Service Area – "CBSA". This service area may differ from your primary service area on page 1. Please describe in detail.)

   b. In Table II, describe significant demographic characteristics and social determinants that are relevant to the needs of the community and include the source of the information in each response. For purposes of this section, social determinants are factors that contribute to a person's current state of health. They may be biological, socioeconomic, psychosocial, behavioral, or social in nature. (Examples: gender, age, alcohol use, income, housing, access to quality health care, having or not having health insurance.) (Add rows in the table for other characteristics and determinants as necessary).

   Some statistics may be accessed from the Maryland Vital Statistics Administration (http://vsa.maryland.gov/html/reports.cfm), and the Maryland State Health Improvement Plan (http://dhmh.maryland.gov/ship/).

Table II

Community Benefit Service Area(CBSA) Target Population (target population, by sex, race, and average age)	
Median Household Income within the CBSA	
Percentage of households with incomes below the federal poverty guidelines within the CBSA	
Please estimate the percentage of uninsured people by County within the CBSA This information may be available using the following links: http://www.census.gov/hhes/www/hlthins/data/acs/aff.html; http://www.census.gov/hhes/www/hlthins/data/acs/aff.html; http://planning.maryland.gov/msdc/American_Community_Survey/2009ACS.shtml	
Percentage of Medicaid recipients by County within the CBSA.	

Life Expectancy by County within the CBSA.	
Mortality Rates by County within the CBSA.	
Access to healthy food, quality of housing, and transportation by County within the CBSA. (to the extent information is available from local or county jurisdictions such as the local health officer, local county officials, or other resources)	
Other	
Other	

II. COMMUNITY HEALTH NEEDS ASSESSMENT

According to the Patient Protection and Affordable Care Act ("ACA"), hospitals must perform a community health needs assessment either fiscal year 2011, 2012, or 2013, adopt an implementation strategy to meet the community health needs identified, and beginning in 2013, perform an assessment at least every three years thereafter. The needs assessment must take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health, and must be made widely available to the public.

For the purposes of this report, a community health needs assessment is a written document developed by a hospital facility (alone or in conjunction with others) that utilizes data to establish community health priorities, and includes the following:

(1) A description of the process used to conduct the assessment;
(2) With whom the hospital has worked;
(3) How the hospital took into account input from community members and public health experts;
(4) A description of the community served; and
(5) A description of the health needs identified through the assessment process.

Examples of sources of data available to develop a community health needs assessment include, but are not limited to:

(1) Maryland Department of Health and Mental Hygiene's State Health improvement plan (http://dhmh.maryland.gov/ship/);
(2) Local Health Departments;
(3) County Health Rankings (http://www.countyhealthrankings.org);
(4) Healthy Communities Network (http://www.healthycommunitiesinstitute.com/index.html);
(5) Health Plan ratings from MHCC (http://mhcc.maryland.gov/hmo);
(6) Healthy People 2020 (http://www.cdc.gov/nchs/healthy_people/hp2010.htm);
(7) Behavioral Risk Factor Surveillance System (http://www.cdc.gov/BRFSS);
(8) Focused consultations with community groups or leaders such as superintendent of schools, county commissioners, non-profit organizations, local health providers, and members of the business community;
(9) For baseline information, a Community health needs assessment developed by the state or local health department, or a collaborative community health needs assessment involving the hospital; Analysis of utilization patterns in the hospital to identify unmet needs;
(10) Survey of community residents
(11) Use of data or statistics compiled by county, state, or federal governments; and
(12) Consultation with leaders, community members, nonprofit organizations, local health officers, or local health care providers. .

1. Identification of Community Health Needs:
   Describe in detail the process(s) your hospital used for identifying the health needs in your community and the resource(s) used.

2. In seeking information about community health needs, what organizations or individuals outside the hospital were consulted?

3. When was the most recent needs identification process or community health needs assessment completed?
   Provide date here. __/__ /__ (mm/dd/yy)

4. Although not required by federal law until 2013, has your hospital conducted a community health needs assessment that conforms to the definition on the previous page within the past three fiscal years?
   ___Yes
   ___No

   If you answered yes to this question, please provide a link to the document or attach a PDF of the document with your electronic submission.

III. COMMUNITY BENEFIT ADMINISTRATION

1. Please answer the following questions below regarding the decision making process of determining which needs in the community would be addressed through community benefits activities of your hospital?

a. Does your hospital have a CB strategic plan?

___Yes
___No

b. What stakeholders in the hospital are involved in your hospital community benefit process/structure to implement and deliver community benefit activities? (Please place a check next to any individual/group involved in the structure of the CB process and provide additional information if necessary):

i. Senior Leadership

1. ___CEO
2. ___CFO
3. ___Other (please specify)

ii. Clinical Leadership

1. ___Physician
2. ___Nurse
3. ___Social Worker
4. ___Other (please specify)

iii. Community Benefit Department/Team

1. ___Individual (please specify FTE)
2. ___Committee (please list members)
3. ___Other (please describe)

c. Is there an internal audit (i.e., an internal review conducted at the hospital) of the Community Benefit report?

Spreadsheet	_____yes	_____no
Narrative	_____yes	_____no

d. Does the hospital's Board review and approve the completed FY Community Benefit report that is submitted to the HSCRC?

Spreadsheet	_____yes	_____no
Narrative	_____yes	_____no

IV. HOSPITAL COMMUNITY BENEFIT PROGRAM AND INITIATIVES

1. Please use Table III (see attachment) to provide a clear and concise description of the needs identified in the process described above, the initiative undertaken to address the identified need, the amount of time allocated to the initiative, the key partners involved in the planning and implementation of the initiative, the date and outcome of any evaluation of the initiative, and whether the initiative will be continued. Use at least one page for each initiative (at 10 point type).

For example: for each major initiative where data is available, provide the following:

   a. Identified need: This includes the community needs identified in your most recent community health needs assessment.

   b. Name of Initiative: insert name of initiative.

   c. Primary Objective of the Initiative: This is a detailed description of the initiative and how it is intended to address the identified need. (Use several pages if necessary)

   d. Single or Multi-Year Plan: Will the initiative span more than one year? What is the time period for the initiative?

   e. Key Partners in Development/Implementation: Name the partners (community members and/or hospitals) involved in the development/implementation of the initiative. Be sure to include hospitals with which your hospital is collaborating on this initiative.

   f. Date of Evaluation: When were the outcomes of the initiative evaluated?

   g. Outcome: What were the results of the initiative in addressing the identified community health need, such as a reduction or improvement in rate? (Use data when available).

   h. Continuation of Initiative: Will the initiative be continued based on the outcome?

2. Were there any primary community health needs that were identified through a community needs assessment that were not addressed by the hospital? If so, why not?

V. PHYSICIANS

1. As required under HG§19-303, provide a written description of gaps in the availability of specialist providers, including outpatient specialty care, to serve the uninsured cared for by the hospital.

2. If you list Physician Subsidies in your data in category C of the CB Inventory Sheet, please indicate the category of subsidy, and explain why the services would not otherwise be available to meet patient demand. The categories include: Hospital-based physicians with whom the hospital has an exclusive contract; Non-Resident house staff and hospitalists; Coverage of Emergency Department Call; Physician provision of financial assistance to encourage alignment with the hospital financial assistance policies; and Physician recruitment to meet community need.

VI. APPENDICES

To Be Attached as Appendices:

1. Describe your Charity Care policy:
    a. Describe how the hospital informs patients and persons who would otherwise be billed for services about their eligibility for assistance under federal, state, or local government programs or under the hospital's charity care policy. (label appendix 1)

    For ***example***, state whether the hospital:

    - posts its charity care policy, or a summary thereof, and financial assistance contact information in admissions areas, emergency rooms, and other areas of facilities in which eligible patients are likely to present;
    - provides a copy of the policy, or a summary thereof, and financial assistance contact information to patients or their families as part of the intake process;
    - provides a copy of the policy, or summary thereof, and financial assistance contact information to patients with discharge materials;
    - includes the policy, or a summary thereof, along with financial assistance contact information, in patient bills; and/or
    - discusses with patients or their families the availability of various government benefits, such as Medicaid or state programs, and assists patients with qualification for such programs, where applicable.

    b. Include a copy of your hospital's charity care policy (label appendix 2).

2. Attach the hospital's mission, vision, and value statement(s) (label appendix 3).

Table III

Initiative 1.

Identified Need	Hospital Initiative	Primary Objective of the Initiative	Single or Multi-Year Initiative Time Period	Key Partners and/or Hospitals in initiative development and/or implementation	Evaluation dates	Outcome	Continuation of Initiative

Table III

Initiative 2.

Identified Need	Hospital Initiative	Primary Objective of the Initiative	Single or Multi-Year Initiative Time Period	Key Partners and/or Hospitals in initiative development and/or implementation	Evaluation dates	Outcome	Continuation of Initiative

Table III

Initiative 3.

Identified Need	Hospital Initiative	Primary Objective of the Initiative	Single or Multi-Year Initiative Time Period	Key Partners and/or Hospitals in initiative development and/or implementation	Evaluation dates	Outcome	Continuation of Initiative

Table III

Initiative 4.

Identified Need	Hospital Initiative	Primary Objective of the Initiative	Single or Multi-Year Initiative Time Period	Key Partners and/or Hospitals in initiative development and/or implementation	Evaluation dates	Outcome	Continuation of Initiative

Table III

Initiative 5.

Identified Need	Hospital Initiative	Primary Objective of the Initiative	Single or Multi-Year Initiative Time Period	Key Partners and/or Hospitals in initiative development and/or implementation	Evaluation dates	Outcome	Continuation of Initiative

Community Benefit Reporting Narrative Evaluation Criteria – Effective FY 2011 reporting peroid.

Hospital Name: _____ Point Total: _____ out of 151 pts.

I. GENERAL HOSPITAL DEMOGRAPHICS AND CHARATERISTICS - total 12 pts

1. What was the licensed bed designation, number of inpatient admissions, the primary service area, and primary service area overlap with other hospitals in the fiscal year? (0 pts)
2. For purposes of reporting on your community benefit activities, describe the community your organization serves.
    a. Is the Community Benefit Service Area (CBSA) described in appropriate detail?
    ___ (0-6 pts)

    b. Are the significant demographic characteristics that are relevant to the needs that the hospital seeks to meet described?
    ___ (0-6 points)

II. COMMUNITY HEALTH NEEDS ASSESSMENT - total 25 pts

1. Are the process(s) and resource(s) used for indentifying the health needs in the community described in appropriate detail?
    ___ (0-10 pts)

2. Did the hospital consult with outside organizations and individuals to seek information about community health needs? Scoring should be based the breadth and appropriateness of these consults.
    ___ (0-10 pts)

3. Is the date of the most recent needs identification process or community health needs assessment provided?
    ___ Yes (5 pts)
    ___ No (0pts)

4. Although not required by federal law until 2013, did the hospital conduct a community health needs assessment that conforms to the definition in the narrative instructions, in the past three fiscal years?
    ___Yes
    ___No

III. COMMUNITY BENEFIT ADMINISTRATION– total 37 pts

1. Does the report indicate who was involved in the decision making process for determining which needs in the community would be addressed through the Community Benefit activities?

   a. Does the hospital have a CB strategic plan?
   ___Yes (5 pts)
   ___No (0 pts)

   b. Are the following included in the process/structure of implementing and delivering Community Benefit Activities?

   i. Senior Leadership
   ___ Yes (5 pts)
   ___ No (0 pts)

   ii. Clinical Leadership
   ___ Yes (5 pts)
   ___ No (0 pts)

   iii. Community Benefit Department/Team
   ___ Yes (5 pts)
   ___ No (0 pts)

   iv. Other (described in sufficient detail)
   ___Yes (5 pts)
   ___No (0 pts)

   c. Does the hospital conduct an internal audit the Community Benefit Report

   i. Spreadsheet:
   ___Yes (3 pts)
   ___No (0 pts)

   ii. Narrative:
   ___Yes (3 pts)
   ___No (0 pts)

   d. Does the hospital Board review and approve the completed Community Benefit Report

   i. Spreadsheet:
   ___Yes (3 pts)
   ___No (0 pts)

   ii. Narrative:

   ___ Yes (3 pts)
   ___No (0 pts)

IV. HOSPITAL COMMUNITY BENEFIT PROGRAM AND INITIATIVES – Total of 50 pts

1. Does the report describe in sufficient detail the identified community needs and initiatives undertaken by the hospital?

   ___ (0-20)

   Does the report describe in sufficient detail the timing, key partners, process for evaluation, and outcomes of the key initiatives?

   ___ (0-20)

2. Does the report provide a list of needs that were identified through a community needs assessment but were not addressed by the hospital? If not, was there appropriate justification?

   ___ (0-10)

V. PHYSICIANS – Total of 10 pts

1. Does the report include a written description of the gaps in availability of specialist providers to serve the uninsured cared for by the hospital?
   ___Yes (5 pts)
   ___No (0 pts)

2. If the hospital listed physician subsidies in Category C, did the hospital provide detail on those subsidies?
   ___Yes (5 pts)
   ___No (0 pts)

VI. APPENDICIES Total – 15 pts

1. Charity Care Policies:
   a. Appendix I – Did the hospital describe how it informs patients about eligibility for assistance under the hospital's charity care policy?

      ___Yes (5 pts)
      ___No (0 pts)

   b. Appendix II – Did the hospital attach a copy of the Charity Care Policy?
      ___Yes (5 pts)
      ___No (0 pts)

2. Mission, Vision and Value statements
   a. Appendix III – Did the hospital attach a copy of the mission, vision, and value statement?
      ___ Yes (5 pts)
      ___ No (0 pts)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Frederick W. Puddester
Chairman

Kevin J. Sexton
Vice Chairman

Joseph R. Antos, Ph.D.

George H. Bone, M.D.

C. James Lowthers

Herbert S. Wong, Ph.D.

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Hospital Rate Setting

Mary Beth Pohl
Deputy Director
Research and Methodology

TO: Commissioners

FROM: Legal Department

DATE: June 29, 2011

RE: Hearing and Meeting Schedule

Public Session:

August 3, 2011 Time to be determined, 4160 Patterson Avenue, HSCRC Conference Room

September 7, 2011 Time to be determined, 4160 Patterson Avenue, HSCRC Conference Room

The Agenda for the Executive and Public Sessions will be available for your review on the Commission's website on the Thursday before the Commission meeting. To review the Agenda, visit the Commission's website at:
http://www.hscrc.state.md.us/CommissionMeetingSchedule.cfm

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