STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

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484th MEETING OF THE HEALTH SERVICES COST REVIEW COMMISSION
December 8, 2011

EXECUTIVE SESSION
9:30 a.m.

1. **Personnel and Waiver Issues**

PUBLIC SESSION
10:00 A.M.

1. **Review of the Executive Session and Public Meeting Minutes of November 2, 2011 Meeting**

2. **Executive Director's Report**

3. **Docket Status – Cases Closed**

   2128A – MedStar Health
   2131A – Maryland Physicians Care
   2135A – Johns Hopkins Health System
   2137A – University of Maryland Medical Center
   2138A – University of Maryland Medical Center
   2139A – University of Maryland Medical Center
   2140A – Johns Hopkins Health System
   2141A – Johns Hopkins Health System
   2142A – Johns Hopkins Health System

4. **Docket Status – Cases Open**

   2143A – The Johns Hopkins Health system
   2144A – MedStar Health
   2145A – The Johns Hopkins Health System

5. **Final Recommendation on Revisions to the Labor and Delivery Relative Value Units (RVUs)**

6. **Draft Recommendation regarding Hospital GME Reporting Changes to Schedules P4A to P4I (DME) and Schedule IRS (IME)**

7. **Legal Report**

8. **Hearing and Meeting Schedule**

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

AS OF NOVEMBER 28, 2011

A: PENDING LEGAL ACTION : NONE
B: AWAITING FURTHER COMMISSION ACTION: NONE
C: CURRENT CASES:

Docket Number	Hospital Name	Date Docketed	Decision Required by:	Rate Order Must be Issued by:	Purpose	Analyst's Initials	File Status
2143A	The Johns Hopkins Health System	10/25/2011	N/A	N/A	ARM	DNP	OPEN
2144A	MedStar Health	11/2/2011	N/A	N/A	ARM	DNP	OPEN
2145A	The Johns Hopkins Health System	11/21/2011	N/A	N/A	ARM	DNP	OPEN

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: 1953**
BALTIMORE, MARYLAND	*	**PROCEEDING: 2143A**

Staff Recommendation

December 8, 2011

I. INTRODUCTIO N

Johns Hopkins Health System (System) filed an application with the HSCRC on October 25, 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 transplant, bone marrow transplant, and cardiovascular services with Olympus Managed Health for a period of one year beginning November 1, 2011.

II. OVE RVIEW 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. I DENTIFICATION 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. ST AFF 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 solid organ, bone marrow transplant, and cardiovascular services for a one year period commencing November 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**
MEDSTAR HEALTH	*	**DOCKET: 2011**
	*	**FOLIO: 1954**
BALTIMORE, MARYLAND	*	**PROCEEDING: 2144A**

Staff Recommendation

December 8, 2011

I. INTRODUCTION

MedStar Health filed an application with the HSCRC on November 2, 2011 on behalf of Union Memorial Hospital (the Hospital) for an alternative method of rate determination (ARM), pursuant to COMAR 10.37.10.06. MedStar requests approval from the HSCRC to continue to participate in a global rate arrangement for orthopedic services with the NFL Player Joint Replacement Benefit Plan (the NFL Plan) for a one year period beginning December 1, 2011.

This arrangement was originally approved by the Commission at its December 5, 2007 public meeting for one year and subsequently re-approved in 2008, and 2009 with the approval expiring on December 1, 2010. The arrangement was reproved again at the March 2, 2011 public meeting. While there has never been any activity, the NFL Plan and the Hospital wish to maintain the arrangement.

II. OVERVIEW OF APPLICATION

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

III. FEE DEVELOPMENT

The hospital portion of the global rates was developed by calculating the mean historical charges for all patients receiving the procedures for which global rates are to be paid. The negotiated rates are comparable to another joint replacement ARM already approved by the HSCRC. The NFL Plan agreement does not include the more costly procedures to replace prior joint replacements. In addition, the agreement does not include the post-acute rehabilitation normally included in joint replacement global pricing. The remainder of the global rate is comprised of physician service costs.

IV. IDENTIFICATION AND ASSESSMENT OF RISK

The Hospital will continue to submit bills to HRMI for all contracted and covered services. HRMI is responsible for billing the payer, collecting payments; disbursing payments to

the Hospital at its full HSCRC approved rates, and reimbursing the physicians. The Hospital contends that the arrangement between HRMI and the Hospital holds the Hospital harmless from any shortfalls in payment from the global price contract.

V. STAFF EVALUATION

The staff believes that the hospital component of the global rate is reasonably related to historical experience. Staff has noted that the NFL Plan agreement has a more narrower definition of the episode of care covered under the global rates than other similar ARM arrangements. In addition, staff found that the Hospital and HRMI have a favorable history of managing joint replacement patients and performing under a global rate arrangement. The physicians professional components of the proposed rates follow historical fee for service averages and are closely related to the professional components of the Hospitals similar global arrangement involving orthopedic surgery.

VI. STAFF RECOMMENDATION

Although there has been no activity, staff still believes that the Hospital can achieve favorable performance under this arrangement. Therefore, staff recommends that the Commission approve the Hospital's participation in the alternative method of rate determination for orthopedic services for a one year period, commencing December 1, 2011. The Hospital will need to file a renewal application for review to be considered for continued participation.

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

IN RE: THE APPLICATION FOR	*****	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*****	**SERVICES COST REVIEW**	
DETERMINATION	*****	**COMMISSION**	
JOHNS HOPKINS HEALTH	*****	**DOCKET:**	**2011**
SYSTEM	*****	**FOLIO:**	**1955**
BALTIMORE, MARYLAND	*****	**PROCEEDING:**	**2145A**

Staff Recommendation

December 8, 2011

I. INTRODUCTION

Johns Hopkins Health System (System) filed an application with the HSCRC on November 21, 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 cardiovascular and orthopedic services with PepsiCo, Inc. for a period of one year beginning December 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 cardiovascular and orthopedic 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 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 cardiovascular and orthopedic services for a one year period commencing December 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.

Staff Recommendation

December 8, 2011

The Commission staff recommends for final adoption revisions to the Relative Value Unit (RVU) Scale for Labor and Delivery (DEL). These revised RVUs were developed by a sub-group of the Maryland Hospital Association's HSCRC Technical Issues Task Force. The sub-group's membership represented the Labor and Delivery department of many of the Maryland hospitals located throughout the state. The RVU scale was updated to reflect the current services provided to obstetric patients for DEL services. The revised RVUs were approved by the Maryland Hospital Association's HSCRC Technical Issues Task Force. At your direction staff sent these revisions for review and public comment. No comments were received during the comment period. Hospitals will be required to calculate conversion factors to assure no change in hospital revenue as a result of this revision. Hospitals will begin using these revised RVUs on July 1, 2012.

APPENDIX D
STANDARD UNIT OF MEASURE REFERENCES

Account Number	Cost Center Title
7010	Labor and Delivery Service

Labor and Delivery Service

The Labor and Delivery Relative Value Units were developed by an industry task force under the auspices of the Maryland Hospital Association. These Relative Value Units will be used as the standard unit of measure related to the output of the Labor and Delivery Revenue Center.

All time reflects standard of 1 RVU = 15 minutes of direct RN care. Charges made to Labor and Delivery RVUs must reflect an entire procedure or event occurring in the Obstetrical suite without duplication, support, or charges to other areas using RVUs, minutes, or hours per patient day at the same time. As an example a short stay D&C cannot be charged RVUs plus OR minutes; a sonogram cannot be charged RVUs to Labor and Delivery and to Radiology. Each institution should designate where a procedure is to be charged based on where that procedure is performed. For any Labor and Delivery OR suite procedure, RVUs or Minutes may be charged, but not both.

PRIMARY OBSTETRICAL Procedures:

These procedures include physical assessment, pregnancy history, and vital signs. Delivery procedures are excluded. RVUs are assigned on the basis of RN time only in relation to these procedures. Charges for these may be in addition to Obstetrical charges. (See section to follow entitled: L & D Observation/Triage services.)

Procedures:	**RVUs:**
Amniocentesis - Diagnostic	3
Biophysical Profile with NST	5
Biophysical Profile w/o NST	4
Cervical Cerclage	10
Dilation & Curettage (D&C)	9
Dilation and Evacuation (D&E)	9
Doppler Flow Evaluation	1
External Cephalic Versions	10
*Minor OR procedure, emergent or non-emergent, w/o delivery	8
*Major OR procedure, emergent or non-emergent, w/o delivery	38
Non Stress Test, Fetal	5
Oxytocin Stress Test	5
Periumbilical Blood Sampling (PUBS)	18 (+ 4 w/multiples)
Periumbilical Blood Sampling (PUBS) double set up w/OR	2
Ultrasound, OB (read by Obstetrics only)	3

* The classification of minor and major procedures is related to the complexity of the case and the nursing work load required for patient care. The lists below are examples of procedures in each category, but the classification is not limited to these examples.

Minor:	Major:
Cerclage insertion or removal	Bladder repair
Incision and Drainage (I&D)	Bowel repair
Needle membrane	Hernia repair
Tubal ligation	Hysterectomy
Wound care	Oopherectomy

***** "Minor" surgery is any invasive operative procedure in which only skin or mucous membranes and connective tissue is resected, e.g., vascular cut down for catheter placement, implanting pumps in subcutaneous tissue. Also included are procedures involving biopsies or placement of probes or catheters requiring the entry into a body cavity through a needle or trocar in combination with a "minor" surgical procedure.

* "Major" surgery is any invasive operative procedure in which extensive resection is performed, e.g., a body cavity is entered, organs are removed, or normal anatomy is significantly altered. For surgical procedures that do not clearly fall in the above categories, the chance for significant inadvertent infection of the surgical site is to be a primary consideration.

The definition of Emergent and Non-emergent is based on timing also known as the “decision to incision time”. An emergent procedure is performed within 30 minutes of the physician’s decision. A non-emergent procedure is performed after that 30 minute window has passed.

DELIVERY Procedures:

The following procedures are primarily inpatient services, however if any are performed on an outpatient basis hospitals should apply the most appropriate CPT codes.

Procedures (SELECT ONLY ONE):	**RVUs:**
Fetal Demise/Genetic Termination 2nd or 3rd Trimester	30
Fetal Demise/Genetic Termination 2nd or 3rd Trimester w/Epidural	36
Delivery outside the hospital, prior to arrival	12
Vaginal Delivery (No anesthesia, uncomplicated)	24
Vaginal Delivery w/Vacuum/Forceps Assistance	26
Vaginal Delivery w/Epidural Anesthesia	30
Vaginal Delivery w/Epidural w/Forceps/Vacuum Assistance	32
Vaginal Delivery after prior C-section (VBAC)	32
Cesarean Section, non-emergent	18
Cesarean Section, non-emergent w/minor surgery	20
Cesarean Section, non-emergent w/major surgery	31
Cesarean Section, Emergency	37
Cesarean Section, emergent w/minor surgery	39
Cesarean Section, emergent w/major surgery	61

OBSTETRICAL ADD ON TO DELIVERY Procedures:

These are procedures that are performed in addition to the core procedures listed above.

Procedures (ALL THAT APPLY):	**RVUs:**
Amnioinfusion	6
Double Set-Up/Failed Forceps/Vacuum	2
Induction/Augmentation w/delivery	4
Intrauterine Pressure Catheter Monitoring (IUPC)	2
Multiple Birth: Twins	6
Multiple Birth: Triplets	9
Multiple Birth: Quads	12
Neonatal Resuscitation (APGAR < 6 @ 1 minute; PH < 7.2)	4

POSTPARTUM OBSTETRICAL SURGICAL Procedures:

The following procedures are listed to capture RVUs for postpartum obstetrical surgeries that occur after an episode of delivery, vaginal or cesarean section. Please refer to the top of page 2 for the definition and examples of minor and major procedures.

Procedures (SELECT ONLY ONE):	**RVUs:**
Surgery, Additional minor, non-emergent	8
Surgery, Additional major, non-emergent	19
Surgery, Additional minor, emergent	16
Surgery, Additional major, emergent	38

MISCELLANEOUS Procedures:	**RVUs:**
Circumcision (even if performed in Nursery)	3
Oocyte Retrieval	10
Gamete Intrafallopian Tube Transfer (GIFT)/Tubal Embryo Transfer	16

ASSESSMENT/TRIAGE and OBSERVATION Services:

Hospitals should determine the most appropriate level of Assessment/Triage, the use of Observation, and Maternal Intensive Care; then apply the most appropriate observation and/or evaluation and management code depending on the physician order.

Services:	**RVUs:**
Assessment/Triage Service	1

Assessment/Triage services may include, but are not limited to performing a health and physical assessment, pregnancy history, and vital signs.

Outpatient Maternal Observation 1 per hour (15 min direct RN time per hour)

Observation is a valid clinical service. The primary purpose of observation services in L&D is to determine whether the patient should be admitted as an inpatient. The service includes the use of a hospital bed and monitoring, by the facility's nursing or other staff, deemed reasonable and necessary to evaluate the patient's condition to determine whether she should be admitted.

Outpatient Maternal Observation minutes should be rounded up to the nearest full hour. This should be interpreted to mean that 30 minutes = 0 RVUs, 31 minutes = 1 RVU, 75 minutes = 1 RVU, etc…

Some common examples of providing observation and triage services included but not limited to are:

1) Labor evaluation
2) Cervical ripening
3) Fetal monitoring
4) Motor Vehicle Accident
5) IV hydration

MATERNAL INTENSIVE CARE (MIC) **RVUs:**

Outpatient Maternal Intensive Care 2 RVUs per hour (30 min direct RN time per hour)

This category is reserved for patients prior to delivery requiring on-going intensive nursing care. This category may be charged only during the period of intensive interventions. Note: Patients who have been admitted and require on-going intensive nursing care should be reported with the applicable inpatient care room and board rate and not Maternal Intensive Care. Examples of disease processes with designated pharmaceutical and or nursing interventions are listed below but the examples are not all inclusive.

Diagnoses:
Cardiac Disease
Bleeding Disorders
Disseminated Intravascular Coagulation (DIC)
Diabetes Mellitus
Hypertensive Disorder of Pregnancy (HDP)
Preterm labor
Multisystem Disorders
Asthma

Examples of pharmaceuticals and nursing care for MIC include but are not limited to the following:

Pharmaceutical:
Magnesium Sulfate
Ritodrine
Terbutaline (repeated SQ doses)
Aminophylline
Insulin IV drip
Apresoline
Heparin Sulfate
Phenytoin Sodium (Dilantin)
Pitocin
Nifedipine
Labatalol
AZT drip
IVIG Drip

Nursing Care:
Blood Transfusions
Nebulizer Therapy
Invasive Hemodynamic Monitoring
Conscious Sedation procedures
- a) PUBS
- b) Fetal surgery
- c) Fetal exchange transfusion

Ventilation Therapy
Labor/Delivery care on another unit

Summary of Changes to LD Appendix D Effective FY 2013

FY 2013 Description	Current Description	FY 2013 RVU	Current RVU
PRIMARY OBSTETRICAL Procedures:			
Amniocentesis - Diagnostic	Amniocentesis	3	3
Biophysical Profile with NST	Biophysical Profile	5	5
Biophysical Profile w/o NST	-	**4**	**NEW**
Cervical Cerclage	Cervical Cerclage	10	10
Dilation & Curettage (D&C)	D&C, =&C or Minor Surgery Short Stay without Delivery Charges	9	9
Dilation and Evacuation (D&E)	-	**9**	**NEW**
Doppler Flow Evaluation	Doppler Flow Evaluation	1	1
External Cephalic Versions	External Versions	10	10
*Minor OR procedure, emergent or non-emergent, w/o delivery	D&C, = &C or Minor Surgery Short stay without Delivery Charges	8	9
*Major OR procedure, emergent, w/o delivery	Hysterectomy or other major operative procedure (unscheduled emergency)	38	ADD ON 38
Non Stress Test, Fetal	Non-Stress Test	5	5
Oxytocin Stress Test	Oxytocin Stress Test	5	5
Periumbilical Blood Sampling (PUBS)	-	**18 (+ 4 w/multiples)**	**NEW**
Periumbilical Blood Sampling (PUBS) double set up w/OR	-	**2**	**NEW**
Ultrasound, OB (read by Obstetrics only)	OB Ultrasound (performed and read by Obstetrics Only with no involvement of radiology	3	3
Delivery Procedures:			
Fetal Demise/Genetic Termination 2nd or 3rd Trimester	Fetal Demise 3rd trimester (C/S, vag.) add ADD ON TO PROCEDURE	30	ADD ON 6
Fetal Demise/Genetic Termination 2nd or 3rd Trimester w/Epidural	-	**36**	**NEW**
Delivery Outside the hospital, prior to arrival	Delivery outside department	12	12
Vaginal Delivery (No anesthesia, uncomplicated)	Vaginal birth (no anesthesia uncomplicated)	24	24
Vaginal Delivery w/Vacuum/Forceps Assistance	Vaginal birth with vacuum/forcep assistance	26	26
Vaginal Delivery w/Epidural Anesthesia	Vaginal birth with epidural anesthesia	30	30
Vaginal Delivery w/Epidural w/Forceps/Vacuum Assistance	Vaginal birth with epidural anesthesia with vacuum/forceps	32	32
Vaginal Delivery after prior C-section (VBAC)	Vaginal birth after previous C-section (VBAC)	32	32
Cesarean Section, non-emergent	C-Section scheduled	18	18
Cesarean Section, non-emergent w/minor surgery	C-section scheduled with tubal ligation	20	19
Cesarean Section, non-emergent w/major surgery	-	**31**	**NEW**
Cesarean Section, Emergency	C-section non-scheduled emergency	37	37
Cesarean Section, emergent w/minor surgery	C-section non-scheduled emergency with tubal ligation	39	38
Cesarean Section, emergent w/major surgery	C-Section non-scheduled + add on major surgery (Hysterectomy or other major procedure - unscheduled)	61	75
OBSTETRICAL ADD ON TO DELIVERY Procedures:			
Amnioinfusion	-	**6**	**NEW**
Double Set-Up/Failed Forceps/Vacuum	Double set-up (C/S or vag.) or failed forceps/vacuum add	2	2
Induction/Augmentation w/delivery	Induction/Augmentation (C/S, vag.) add ADD ON TO PROCEDURE	4	4
Intrauterine Pressure Catheter Monitoring (IUPC)	-	**2**	**NEW**
Multiple Birth: Twins	Multiple birth twins	6	6
Multiple Birth: Triplets	each multiple birth	9	9
Multiple Birth: Quads	each multiple birth	12	12
Neonatal Resuscitation (APGAR < 6 @ 1 minute; PH < 7.2)	Neonatal resuscitation with apgars less than 6 at one minute, or arterial cord blood PH less than 7.2 add	4	4
POSTPARTUM OBSTETRICAL SURGICAL Procedures:			
*Surgery, Additional minor, non-emergent	L&D OR Additional minor surgical procedure	8	ADD ON 8
***Surgery, Additional major, non-emergent**	-	**19**	**NEW**
***Surgery, Additional minor, emergent**	-	**16**	**NEW**
***** **Surgery, Additional major, emergent**	Hysterectomy or other major operative procedure (unscheduled emergency) ADD ON TO PROCEDURE	38	ADD ON 38
MISCELLANEOUS Procedures:			
Circumcision (even if performed in Nursery)	Circumcision (even if performed in Nursery)	3	ADD ON 3
Oocyte Retrieval	Oocyte Retrieval	10	10
Gamete Intrafallopian Tube Transfer (GIFT)/Tubal Embryo Transfer	Gamete Intrafallopian Tube Transfer (GIFT)	16	16
L&D ASSESSMENT/TRIAGE and OBSERVATION Services:			
Assessment/Triage Service	-	**1**	**NEW**
Outpatient Maternal Observation	Observe: Maternal and/or Fetal Assessment	1 per hour	1 per hour
Outpatient Maternal Intensive Care	Maternal Intensive Care	2 RVUs per hour	2 RVUs per hour
DELETED PROCEDURES from Current Appendix D			
-	Hysterectomy or other major operative procedure (scheduled routine)	Deleted	18
-	Nipple Stimulation Stress Test	Deleted	5
-	Induction without Labor	Deleted	8
-	Abortion (spontaneous or elective) 2nd trimester	Deleted	12
-	Neonatal ongoing assessment greater than one hour add	Deleted	2
-	Screening Auditory Brainstem Response	Deleted	1
-	Tubal Embryo Transfers (T.E.T)	Deleted	16
-	Otoacoustic Emission	Deleted	1

Hospital Graduate Medical Education Reporting Changes to Schedules P4A to P4I (Direct Medical Education) and Schedule IRS (Indirect Medical Education)

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

December 8, 2011

This is a draft recommendation. Comments may be submitted to Mary Beth Pohl (mpohl@hscrc.state.md.us) by December 31, 2011.

Purpose

This is a draft recommendation regarding changes to hospital graduate medical education (GME) financial and resident count reporting.

HSCRC staff utilizes the GME financial reporting for calculating dollars attributed to direct medical education (DME). HSCRC staff utilizes the resident[1] count report to quantify the added cost to patient charges attributable to training (indirect medical education, or IME). The changes HSCRC staff recommend intend to:

- DME: Update financial schedules to reflect previously implemented policy that discontinued the requirements around hospital reporting of ineligible residents;
- DME: Modify financial schedule instructions to reflect the full time equivalency definition used by Medicare for counting residents;
- IME: Change IME reporting from a one-day snap shot to a FTE based count;
- IME: Modify and clarify IME reporting requirements to follow Medicare resident reporting; and
- IME: Revise the HSCRC's IME collection template to more closely approximate the data format for which hospitals submit resident information to Medicare's Intern and Resident Reporting System (IRIS).

Background

Since its inception, Maryland's all payer system has accounted for the social costs associated with the training of physicians by building costs for DME and IME into hospital rates. The HSCRC does not make payments for DME or IME. Rather, the Commission uses DME and IME adjustments in its methodologies to assess the adequacy of hospital rates relative to peer institutions through the reasonableness of charges (ROC) and the inter-hospital cost comparison (ICC) methodologies.

To account for DME and IME in the ROC and ICC, the Commission requires hospitals to submit annual financial and resident count reports. Hospitals report DME on Schedule P4A to P4I. For DME, the HSCRC quantifies the dollar amount associated with training program components, including salaries/compensation and fringe benefits. Hospitals report the resident count on the HSCRC's Intern and Resident Survey (Schedule IRS). HSCRC staff utilize the resident count in quantifying the added cost to patient charges attributable to training (i.e., inefficiencies). The HSCRC captures IME costs through a regression analysis.

While computing the ROC this summer, HSCRC staff identified an error in hospital reporting of resident counts in the previous year. Following the correction of the error, HSCRC staff opened a discussion with the Payment Workgroup to review and potentially modify HSCRC's collection

[1] For purposes of this recommendation, "resident" may be an intern, resident, or fellow who meets the DME or IME definitions in the GME reporting requirements.

of GME data. New collection practices would aim to provide HSCRC with a more complete understanding of GME and allow for GME data review/auditing.

In October, HSCRC staff engaged a workgroup of hospital representatives to address potential changes to DME and IME reporting. HSCRC staff emailed CFOs at all hospitals with graduate medical education programs. The following hospitals/systems provided representatives for the GME workgroup: Holy Cross, Johns Hopkins, LifeBridge, MedStar, Saint Agnes, and University of Maryland. HSCRC staff copied Maryland Hospital Association representatives on email correspondence with the GME workgroup.

The GME workgroup discussed the potential to consolidate collection of DME and IME information. However, based on HSCRC staff review of Commission policy and Medicare regulation, HSCRC staff recommend continuing to have separate reporting practices for DME and IME. With input from the workgroup, HSCRC staff recommend changes to both DME and IME reporting.

Recommended Updates to DME Reporting

As HSCRC had previously discontinued the requirements around reporting of ineligible residents, the revisions to the financial reporting eliminate Schedule P5. The revised instructions also specify the calculation of resident FTEs utilizing days worked annually.

See Attachment A for the draft Schedule P4A to P4I. Attachment B modifies Section 400, Reporting Requirements of the Accounting and Budget Manual.

Recommended Changes to IME Reporting

Background:

Currently, Schedule IRS, completed by hospitals and due to the HSCRC by January 15th each year, lists interns, residents, and eligible fellows who performed services in that hospital on the Tuesday following Labor Day. Instead of relying on the Schedule IRS's one day snapshot to represent resident counts for the entire year, HSCRC staff reviewed the potential of moving to a FTE count of the time that interns/residents/fellows provided patient care at the hospital. Data similar to those submitted to Medicare's Intern and Resident Information System (IRIS), which provides FTE information for each resident, seems a logical potential replacement.

Note that the HSCRC developed Schedule IRS prior to the federal government's implementation of Medicare's IRIS. Currently hospitals submit resident count data to both the HSCRC and Medicare using different templates and methodologies.

HSCRC Staff Review of Medicare Regulations and the Use of IRIS:

HSCRC reviewed Medicare IME regulations (§412.105), IRIS reporting requirements, and consulted with Medicare's fiscal intermediary to understand the impact of following Medicare regulations for the reporting of IME.

HSCRC staff found that Medicare's IME reporting requirements are substantially in line with the intent of the HSCRC for hospital reporting of resident counts. This includes Medicare regulations regarding the definition of an accredited residency program/inclusion of fellows for purposes of IME, the determination of countable time (e.g., research vs. clinical time), determination of hospital vs. out of hospital, and the definition of full time equivalency seemed

overall to be in line with HSCRC policy. Note that Medicare regulations are far more instructive regarding which residents and which time is accounted for in IME.

The aspect of Medicare IME regulation that most differs from HSCRC reporting requirements is that Medicare does count for IME certain days that a resident spends outside of regulated space when performing patient care activities (e.g., rotations at affiliated physician practices). HSCRC staff has asked the GME workgroup to comment on the extent of resident rotations outside of the regulated space that are countable under Medicare regulation §412.105(f)(1)(ii)(C). We have not received feedback thus far and will continue to request feedback during this recommendation's comment period. Unless HSCRC staff recieve documentation from hospitals to the contrary, HSCRC staff believe that following Medicare policy on this is acceptable.

See Attachment C for the Schedule IRS instructions in the Accounting and Budget Manual. Attachment D is a snapshot of the Schedule IRS template.

Addition of a GME Review/Audit

HSCRC will begin reviews of Schedule IRS submissions Spring 2012 based on the draft GME audit program in Attachment E.

Summary of Recommendations

HSCRC staff recommend changes to hospital reporting of GME:

- DME: Update financial schedules to reflect previously implemented policy that discontinued the requirements around hospital reporting of ineligible residents;
- DME: Modify financial schedule instructions to reflect the full time equivalency definition used by Medicare for counting residents;
- IME: Change IME reporting from a one-day snap shot to a FTE based count;
- IME: Modify and clarify IME reporting requirements to follow Medicare resident reporting; and
- IME: Revise the HSCRC's IME collection template to more closely approximate the data format for which hospitals submit resident information to Medicare's Intern and Resident Reporting System (IRIS).

As this is a draft recommendation, HSCRC will continue to solicit feedback from hospitals and the GME workgroup on the draft Schedule P4A to P4I and Schedule IRS and report back to the Commission with final recommendations at its January Commission meeting.

Attachment A - Draft Schedule P4A to P4I

SCHEDULES P4A TO P4I - RESIDENTS, INTERNS SERVICES .15

Overview .151

Schedules P4A thru P4I are provided to enable each hospital to report the total costs including compensation and fringe benefits for residents, interns and physician supervision of residents, interns services engaged in an organized program of post-graduate medical clinical education for the following cost centers:

Nomenclature	Account Number	Code
Medical Surgical Acute	8240	MSG
Pediatrics Acute	8240	PED
Psychiatric Acute	8240	PSY
Obstetrics Acute	8240	OBS
Definitive Observation	8240	DEF
M/S Intensive Care	8240	MIS
Coronary Care	8240	CCU
Pediatric Intensive Care	8240	PIC
Neo-Natal Intensive Care	8240	NEO
Burn Care	8240	BUR
Psychiatric Intensive Care	8240	PSI
Shock Trauma	8240	TRM
Oncology	8240	ONC
Newborn Nursery	8240	NUR
Premature Nursery	8240	PRE
Rehabilitation	8240	RHB
Intermediate Care	8240	ICC
Emergency Services	8240	EMG
Clinic Services	8240	CL
Psych. Day & Night Care	8240	PDC
Labor & Delivery Services	8240	DEL
Operating Room	8240	OR
Operating Room Clinic	8240	ORC
Anesthesiology	8240	ANS
Laboratory Services	8240	LAB
Electrocardiography	8240	EKG
Interventional Radiology/Cardiovascular	8240	IRC
Radiology-Diagnostic	8240	RAD
CT Scanner	8240	CAT
Radiology-Therapeutic	8240	RAT
Nuclear Medicine	8240	NUC
Respiratory Therapy	8240	RES

Attachment A - Draft Schedule P4A to P4I

Nomenclature	Account Number	Code
Pulmonary Function	8240	PUL
Electroencephalography	8240	EEG
Physical Therapy	8240	PTH
Occupational Therapy	8240	OTH
Speech-Language Pathology	8240	STH
MRI Scanner	8240	MRI
Same Day Surgery	8240	SDS
Lithotripsy	8240	LIT
Rehabilitation	8240	RHB
Adult Psychiatric	8240	PAD
Psychiatric Child/Adolescent	8240	PCD
Psychiatric Intensive Care	8240	PSI
Psycho-Geriatric	8240	PSG
Psychiatric Day Care	8240	PSD
Individual Therapy	8240	ITH
Group Therapy	8240	GTH
Activity Therapy	8240	ATH
Family Therapy	8240	FTH
Psychiatric Testing	8240	PST

The total costs are to be reported for all residents and interns working in the hospital.

The column headed Source indicates computations to be made or the source of the data requested.

Round the expenses on Lines A, B, C, D, E, and F to 1 decimal place (nearest hundred), e.g., $128,610.50 is entered as 128.6.

Round the FTE data on Lines G and H to 1 decimal place, e.g., line G, 1898 days divided by 365 = 5.2 FTEs and line H, 4160 hours divided by 2080 = 2.0 FTEs.

Detailed Instructions .152

Heading Section

Institution Name Line

Enter on this line the complete name of the reporting hospital.

Institution Number Line

Enter on this line, the number assigned to the reporting hospital located in Appendix B. The assigned number corresponds to the last 4 digits of the reporting hospital's Medicare Provider Number, e.g., 0099.

Base Year Line

Enter on this line the year for which the base year data is reported, e.g., 06-12.

Attachment A - Draft Schedule P4A to P4I

Base Year Data Section

Line A - Base Year Wages and Salaries

Schedule P4A- Columns 1 to 7

Schedule P4B- Columns 1 to 7

Schedule P4C - Columns 1 to 7

Schedule P4D - Columns 1 to 7

Schedule P4E - Columns 1 to 7

Schedule P4F - Columns 1 to 7

Schedule P4G - Columns 1 to 7

Schedule P4H - Columns 1 to 7

Schedule P4I - Columns 1 to 6

Enter on this line, in each applicable cost center column, the wages, salaries and fringe benefits expenses incurred in the base year for residents and interns.

Schedule P4I - Column 7

Enter on this line, in the Total Column, the result of adding Line A. Base Year Expenses, from each cost center column, (Schedule P4A, Columns 1 to 7, Schedule P4B, Columns 1 to 7, Schedule P4C, Columns 1 to 7, Schedule P4D, Columns 1 to 7, Schedule P4E, Columns 1 to 7, Schedule P4F, Columns 1 to 7, Schedule P4G, Columns 1 to 7, Schedule P4H, Columns 1 to 7 and Schedule P4I, Columns 1 to 6.)

Line B - Base Year Physician Supervision

Schedule P4A - Columns 1 to 7

Schedule P4B - Columns 1 to 7

Schedule P4C - Columns 1 to 7

Schedule P4D - Columns 1 to 7

Schedule P4E - Columns 1 to 7

Schedule P4F - Columns 1 to 7

Schedule P4G - Columns 1 to 7

Schedule P4H - Columns 1 to 7

Schedule P4I - Columns 1 to 6

Enter on this line, in each applicable cost center column, the physician supervision expenses transferred from Schedules P1A and P1B, Lines A1 to A50, Column 6, Education, except Private Psychiatric hospitals.

Attachment A - Draft Schedule P4A to P4I

Schedule P4I - Column 7

Enter on this line, in the Total Column, the result of adding Line B, Base Year Physician Supervision, from each cost center column, (Schedule P4A, Columns 1 to 7, Schedule P4B, Columns 1 to 7, Schedule P4C, Columns 1 to 7, Schedule P4D, Columns 1 to 7, Schedule P4E, Columns 1 to 7, Schedule P4F, Columns 1 to 7, Schedule P4G, Columns 1 to 7, Schedule P4H, Columns 1 to 7 and Schedule P4I, Columns 1 to 6.)

Line C - Base Year Other Expenses

Schedule P4A - Columns 1 to 7

Schedule P4B - Columns 1 to 7

Schedule P4C and P5C - Columns 1 to 7

Schedule P4D - Columns 1 to 7

Schedule P4E - Columns 1 to 7

Schedule P4F - Columns 1 to 7

Schedule P4G - Columns 1 to 7

Schedule P4H - Columns 1 to 7

Schedule P4I - Columns 1 to 6

Enter on this line, in each applicable cost center column, the other expenses incurred in the base year in the resident, intern program.

Schedule P4I - Column 7

Enter on this line, in the Total Column, the result of adding Line C, Base Year Other Expenses, from each cost center column, (Schedule P4A, Columns 1 to 7, Schedule P4B, Columns 1 to 7, Schedule P4E, Columns 1 to 7, Schedule P4F, Columns 1 to 7, Schedule P4G, Columns 1 to 7, Schedule P4H, Columns 1 to 7 and Schedule P4I, Columns 1 to 6.)

Line D - Total Base Year Expenses

Schedule P4A - Columns 1 to 7

Schedule P4B - Columns 1 to 7

Schedule P4C - Columns 1 to 7

Schedule P4D - Columns 1 to 7

Schedule P4E - Columns 1 to 7

Schedule P4F - Columns 1 to 7

Schedule P4G - Columns 1 to 7

Schedule P4H - Columns 1 to 7

Schedule P4I - Columns 1 to 6

Attachment A - Draft Schedule P4A to P4I

Enter on this line, in each cost center column and the Total Column, the result of adding Line A, Base Year Wages and Salaries, Line B, Base Year Physician Supervision and Line C, Base Year Other Expenses.

Verify the result of adding the base year expenses from each cost center column (Schedule P4A, Columns 1 to 7, Schedule P4B, Columns 1 to 7, Schedule P4C, Columns 1 to 7, Schedule P4D, Columns 1 to 7, Schedule P4E, Columns 1 to 7, Schedule P4F, Columns 1 to 7, Schedule P4G, Columns 1 to 7, Schedule P4H, Columns 1 to 7 and Schedule P4I, Column 1 to 6.) equals the expenses in the Total Column.)

Transfer the total expenses from schedule P4I to Schedule RC, Line D, Column 1, Base Year.

Line E - Allocation from Cafeteria, Parking, Etc.

Schedule P4A - Columns 1 to 7

Schedule P4B - Columns 1 to 7

Schedule P4C - Columns 1 to 7

Schedule P4D - Columns 1 to 7

Schedule P4E - Columns 1 to 7

Schedule P4F - Columns 1 to 7

Schedule P4G - Columns 1 to 7

Schedule P4H - Columns 1 to 7

Schedule P4I - Columns 1 to 6

Enter on this line, in each applicable cost center column, the allocation of cafeteria, parking, etc. from Schedule OADP, lines 204 to 325.

Schedule P4I - Column 7

Enter on this line, in the Total Column, the result of adding the allocation from each cost center column (Schedule P4A, Columns 1 to 7, Schedule P4B, Columns 1 to 7, Schedule P4C, Columns 1 to 7, Schedule P4D, Columns 1 to 7, Schedule P4E, Columns 1 to 7, Schedule P4F, Columns 1 to 7, Schedule P4G, Columns 1 to 7, Schedule H, Columns 1 to 7, and Schedule P4I, Columns 1 to 6.)

Line F - Base Year Expenses Adjusted

Schedule P4A - Columns 1 to 7

Schedule P4B - Columns 1 to 7

Schedule P4C - Columns 1 to 7

Schedule P4D - Columns 1 to 7

Schedule P4E - Columns 1 to 7

Schedule P4F - Columns 1 to 7

Schedule P4G - Columns 1 to 7

Attachment A - Draft Schedule P4A to P4I

Schedule P4H - Columns 1 to 7

Schedule P4I - Columns 1 to 6

Enter on this line, in each cost center column and the Total Column, the result of adding Line A, Base Year Wages and Salaries with Line B, Base Year Physician Supervision and Line C, Base Year Other Expenses.

Verify the result of adding the base year expenses adjusted from each cost center column (Schedule P4A, Columns 1 to 7, Schedule P4B, Columns 1 to 7, Schedule P4C, Columns 1 to 7, Schedule P4D, Columns 1 to 7, Schedule P4E, Columns 1 to 7, Schedule P4F, Columns 1 to 7, Schedule P4G, Columns 1 to 7, Schedule P4H, Columns 1 to 7, and Schedule P4I, Columns 1 to 6 to Schedule P4I, Column 7, Total.)

FTE Data Section

Line G - Base Year Residents and Interns FTE's line (A)

Schedule P4A- Columns 1 to 7

Schedule P4B - Columns 1 to 7

Schedule P4C - Columns 1 to 7

Schedule P4D - Columns 1 to 7

Schedule P4E - Columns 1 to 7

Schedule P4F - Columns 1 to 7

Schedule P4G - Columns 1 to 7

Schedule P4H - Columns 1 to 7

Schedule P4I - Columns 1 to 6

Enter on this line, in each cost center, the total of the result of multiplying each Resident or Intern, individually, by the percentage of the Base Year Worked (based on days worked divided by 365) in that particular cost center, e.g. 8 Residents worked a full year, 7/1 - 6/30, and 1 Resident worked 91 days. Therefore 8 × 100% = 8 and 1 × 25% = .25 or a total of 8.25 Intern/Resident FTE's.

Schedule P4I - Column 7

Enter on this line, in the Total Column, the result of adding the FTEs from each cost center column (Schedule P4A, Columns 1 to 7, Schedule P4B, Columns 1 to 7, Schedule P4C, Columns 1 to 7, Schedule P4D, Columns 1 to 7, Schedule P4E, Columns 1 to 7, Schedule P4F, Columns 1 to 7, Schedule P4G, Columns 1 to 7,Schedule P4H, Columns 1 to 7 and Schedule P4I, Columns 1 to 6.)

Line H - Base Year Hours Worked Physicians Supervision divided by 2080 (B)

Schedule P4A- Columns 1 to 7

Schedule P4B - Columns 1 to 7

Schedule P4C - Columns 1 to 7

Attachment A - Draft Schedule P4A to P4I

Schedule P4D - Columns 1 to 7

Schedule P4E - Columns 1 to 7

Schedule P4F - Columns 1 to 7

Schedule P4G - Columns 1 to 7

Schedule P4H - Columns 1 to 7

Schedule P4I - Columns 1 to 6

Enter on this line, in each cost center, the total of the result of dividing the physician supervision worked hours for the base year by 2080, e.g., 10,912 divided by 2080 = 5.2.

Schedule P4I - Column 7

Enter on this line, in the Total Column, the result of adding the FTEs from each cost center column (Schedule P4A, Columns 1 to 7, Schedule P4B, Columns 1 to 7, Schedule P4C, Columns 1 to 7, Schedule P4D, Columns 1 to 7, Schedule P4E, Columns 1 to 7, Schedule P4F, Columns 1 to 7, Schedule P4G, Columns 1 to 7, Schedule P4H, Columns 1 to 7 and Schedule P4I, Columns 1 to 6.)

Attachment B - Draft Section 400, Reporting Requirements

08/01/11 SECTION 400 1
REPORTING REQUIREMENTS

OVERVIEW

Commission regulation 10.37.01.03 has been amended to authorize the Commission to prescribe the format for the submission of required reports. Effective immediately, reports MUST be filed in the format prescribed below or hospitals will be subject to fines as provided for by COMAR 10.37.01.03 N. Format references can be found at the end of this document.

1. ANNUAL REPORTS

A. Reports due 60 days after the end of the hospital's fiscal year:

1) Annual Debt Collection/Financial Assistance Report –Format #9

B. Reports due 120 days after the end of the hospital's fiscal year:

1) Annual Report of Revenue, Expenses, and Volumes - Format #1

2) Audited Financial Statements - Format #2 & Format #8

3) Trustee Disclosure Information - Format #11

1. List of Trustees with business addresses. Designate individual trustees who have engaged in more than $10,000 of business with the hospital.
2. Individual disclosure form of each trustee doing more than $10,000 of business with the hospital.
3. If no trustees have engaged in more than $10,000 of business with the hospital, the cover letter should so indicate.

4) Credit and Collection Policy – Format #8

C. Report due 140 days after end of fiscal year.

Special Audit Report - Should include audit procedures for alternative method of rate determination if hospital related entity's fiscal year is the same as hospital - Format 1a & Format #8

D. Report due 6 months and 15 days after end of fiscal year

Federal IRS Form 990 – Format # 8

E. Report due June 1 each year

Wage & Salary Report - Format #6

F. Report due December 15th each year

Community Benefit Report – Format #4

G. Report due January 15th or 30 days after the due date of Hospital's Medicare Cost Report

Schedule IRS – Intern, Residents Survey – Format #4

Attachment C - Draft Schedule IRS Instructions

SECTION 500
REPORTING INSTRUCTIONS

SCHEDULE IRS – INTERN, RESIDENTS SURVEY

Overview- Schedule IRS (Intern and Resident Survey) is provided to enable each hospital to report certain intern and resident information for the purpose of calculating the Indirect Medical Education (IME) adjustments for use in HSCRC rate setting methodologies (e.g., Reasonableness of Charges (ROC) and Inter-hospital Cost Comparison (ICC) methodologies).

A supplementary worksheet must accompany the IRS schedule disclosing the reconciling items between your hospital's IRIS (Intern and Resident Information System) Report submitted to the Medicare fiscal intermediary for the period covered by the IRS schedule, and the schedule. The reconciliation worksheet should explain in detail the reason for the differences between the reports.

Schedule IRS is to be submitted annually by January 15th or 30 days after the due date of the hospital's Medicare Cost Report, whichever is later.

Detailed Instructions

Heading Section

Institution Name Line

Enter on this line the complete name of the reporting hospital.

Institution Number Line

Enter on this line the Hospital Identification Number as reported in Appendix B of the HSCRC Accounting and Budget Manual.

Period

Enter on this line the period for which the data are reported.

Reporting Section

Utilizing one line for each Intern/Resident, provide the following information for each Intern/Resident who provides services at your hospital.

Col. 1 Intern/Resident Name- Enter in this column on each line the intern/resident first and last name.

Col. 2 Social Security Number- Enter in this column on each line the intern/resident social security number.

Col. 3 Hospital Employed By- Enter in this column on each line the name of the hospital that employs or provides compensation to the intern/resident.

Attachment C - Draft Schedule IRS Instructions

Col. 4 Medical School- Enter in this column on each line the medical school from which the intern/resident graduated.

Col. 5 ECFMG Certificate Date- If the medical school listed in col.5 is not a US medical school, enter in this column on each line the date that the foreign medical graduate passed the Educational Commission for Foreign Medical Graduates (ECFMG) exam. (If the foreign medical graduate did not pass the ECFMG examination, he/she should not be included in the GME count.)

Col. 6 Program Name- Enter in this column on each line the GME program in which the intern/resident is enrolled.

Col. 7 Program Number- Enter in this column on each line the applicable GME program number of the intern/resident.

Col. 8 Program Year- Enter in this column on each line the number of years in the GME program completed by the intern/resident.

Col. 9 Status Full Time- Enter in this column on each line the word “FULL” if the intern/resident worked full time at the hospital, and the word “PART” if he/she worked part-time.

Col. 10a Patient Care Rotations - Rotation Begin Date - Enter in this column on each line the start date for the intern/resident rotation in which the intern/resident performed patient care activities. Patient care activities included research that is related to the diagnosis and treatment of individual patients.

Col. 10b Patient Care Rotations - Rotation End Date - Enter in this column on each line the end date for the intern/resident rotation in which the intern/resident performed patient care activities. Patient care activities included research that is related to the diagnosis and treatment of individual patients.

Col. 11 Count of Days in Rotation - Enter the count of days in the rotation.

Attachment D - Draft Schedule IRS Template

	A	B	C	D	E	F	G	H	I	J	K	L	M
1	**HSCRC Schedule IRS - Intern and Resident Survey**												
2	**Fiscal Yr:**	FY2012											
3	**Hospital Name:**												
4													
5	**Hospid**	**Intern/Resident Name (First & Last)**	**Social Security Number**	**Name of hospital where intern/resident is employed**	**Medical School**	**ECFMG Certificate Date**	**Program Name**	**Program Number**	**Number of Years Completed**	**Status (Full-time or Part-time)**	**Patient Care Rotation**		**Count of Days in Rotation**
6											**Rotation Begin Date**	**Rotation End Date**	
7		Col 1	Col 2	Col 3	Col 4	Col 5	Col 6	Col 7	Col 8	Col 9	Col 10a	Col 10b	Col 11
8	#N/A												
9	#N/A												
10	#N/A												
11	#N/A												
12	#N/A												
13	#N/A												
14	#N/A												
15	#N/A												
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25	#N/A												
26	#N/A												
27	#N/A												
28	#N/A												
29	#N/A												

Attachment E - Draft GME Audit Program

GRADUATE MEDICAL EDUCATION AUDIT PROGRAM

APPROVAL OF EDUCATIONAL PROGRAMS

1. Using the listings of residents that the hospital submitted to support their FTE count for Graduate Medical Education (GME) identify the residency programs in which the hospital participates. Examine the approval/renewal letters from the appropriate national accrediting organization or information in the Directory of Medical Association Programs published by the American Medical Association or the Annual Report and Reference Handbook published by the American Board of Medical Specialties to determine whether each program is approved by the appropriate organization.

   Note: That a hospital does not have to operate the GME program to be able to count residents for GME purposes. The program however, must be approved at either the hospital or parent institution.

   If the review discloses that the GME program is not approved do not approve the related FTE for GME.

Intern and Resident Information Verification

2. Obtain from the hospital the intern/resident (I/R) folder for each I/R reported on the HSCRC Intern & Resident Survey (IRS). Each I/R folder should have either an intern's resume or residency/program application. Based on review of the intern's resume or application please verify the following:

   - Intern/resident name
   - Social Security Number (SSN)
   - Specialty Program
   - Residency Year
   - Previous Specialty Programs
   - Who is paying intern/resident.
   - Intern/resident or "fellow"

Fellow: A physician in a program of graduate medical education accredited by the Accreditation Council for Graduate Medical Education (ACGME) who has completed the requirements for eligibility for first board certification in the specialty. The term "subspecialty residents" is also applied to such physicians. Other uses of the term "fellow" require modifiers for precision and clarity, e.g., research fellow.

Attachment E - Draft GME Audit Program

GRADUATE MEDICAL EDUCATION (GME) RESIDENT FTE COUNT

3. Verify the accuracy of the GME intern/ residents reported on the hospital's GME FTE spreadsheet.

    - Obtain the hospital's current year listing of all residents that supports the GME FTE count reported on the hospital's GME intern and resident survey (IRS).
    - Obtain from the hospital their GME I/R rotation schedules. Trace I/R from the IRS to their respective rotation schedules. Please note any discrepancies found. Please resolve all discrepancies with the hospital.
    - Obtain from the hospital the letter (s) from the ACGME noting the number of I/R slots that the hospital has been allowed for each approved GME program. Compare the hospital's HSCRC Intern and Resident Survey intern and resident count for each program to ACGME letter (s) and note that those I&R counts that exceed allowed slotting amounts.

Title 10 DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Subtitle 37 HEALTH SERVICES COST REVIEW COMMISSION

Chapter 10 Rate Application and Approval Procedures

Authority: Health-General Article, §§ 19-201, 19-207, and 19-211; Annotated Code of Maryland

NOTICE OF PROPOSED ACTION

The Health Services Cost Review Commission proposes to amend Regulations **.07-1** under **COMAR 10.37.10 Rate Application and Approval Procedures**. This action was considered and approved for promulgation by the Commission at a previously announced open meeting held on December 8, 2011, notice of which was given pursuant to State Government Article, § 10-506(c), Annotated Code of Maryland. If adopted, the proposed amendments will become effective on or about April 16, 2012.

Statement of Purpose

The purpose of this action is to require hospitals to file their request for a determination on the regulated or unregulated status of outpatient services at least 60 days before certain contemplated action.

Comparison of Federal Standards

There is no corresponding federal standard to this proposed action.

Estimate of Economic Impact

The proposed action has no economic impact.

Opportunity for Public Comment

Comments may be sent to Diana M. Kemp, Regulations Coordinator, Health Services Cost Review Commission, 4160 Patterson Avenue, Baltimore, Maryland 21215, or (410) 764-2576, or fax to (410) 358-6217, or email to dkemp@hscrc.state.md.us. The Health Services Cost Review Commission will consider comments on the proposed amendments until February 13, 2012. A hearing may be held at the discretion of the Commission.

.07-1 Outpatient Services – At the Hospital Determination.

A.-E. (1) (text unchanged)

(2) A hospital may not open a new outpatient service, relocate an existing outpatient service, or convert an existing outpatient service from regulated or unregulated status without a prior determination from the Commission's staff as to whether the service is being provided at the hospital. ***A request for determination shall be made in writing at least 60 days before the contemplated action.***

F.-J. (text unchanged)

JOHN M. COLMERS
Chairman
Health Services Cost Review Commission

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

John M. Colmers
Chairman

Joseph R. Antos, Ph.D.

George H. Bone, M.D.

Jack C. Keane

Bernadette C. Loftus, M.D

Thomas R. Mullen

Herbert S. Wong, Ph.D.

Stephen Ports
Acting Executive Director

Gerard J. Schmith
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Hospital Rate Setting

Mary Beth Pohl
Deputy Director
Research and Methodology

HEALTH SERVICES COST REVIEW COMMISSION
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Toll Free: 1-888-287-3229
www.hscrc.state.md.us

TO: Commissioners

FROM: Legal Department

DATE: November 30, 2011

RE: Hearing and Meeting Schedule

Public Session:

January 11, 2011 Time to be determined, 4160 Patterson Avenue, HSCRC Conference Room

February 1, 2012 Time to be determined, 4160 Patterson Avenue, HSCRC Conference Room

Please note, Commissioner packets will be available in the Commission's office at 9:00 a.m.

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

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