STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

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Post-meeting Documents from the

503rd MEETING OF THE HEALTH SERVICES COST REVIEW COMMISSION
December 4, 2013

EXECUTIVE SESSION
12:00 p.m.

1. **Waiver and Personnel Update**
2. **Future Meeting Dates**

PUBLIC SESSION
1:00 p.m.

1. **Review of the Minutes from the Executive Session and Public Meeting on November 6, 2013 and the Executive Session on November 13, 2013** - Approved

2. **Executive Director's Report**

3. **Update on Activities of the Advisory Council on All-Payer Hospital System Modernization**

4. **Docket Status – Cases Closed**

   2220N – University of Maryland Medical Center

5. **Docket Status – Cases Open**
   2182A - John Hopkins Health System Extension Request - Approved

   2234N – Peninsula Reginal Medical Center - Approved
   2235A – Johns Hopkins Health System - Approved
   2236A – Johns Hopkins Health System - Approved
   2237A – Johns Hopkins Health System - Approved

6. **Final Recommendation on Update Factor effective January 1, 2014** - Approved

7. **Final Recommendation on Future Funding Support of the Chesapeake Regional Information System for our Patients (CRISP)** - Approved

8. **Report on FY14 Uncompensated Care Policy and Final Recommendation regarding Charity Care Adjustment** - Approved

9. **Draft Recommendation regarding FY 16 Magnitudes and Standards for the Quality-based Reimbursement, and Maryland Hospital Acquired Conditions Programs**

10. **Hearing and Meeting Schedule**

Executive Session Minutes
Of the
Health Services Cost Review Commission

November 6, 2013

Upon motion made, Chairman Colmers called the Executive Session to order at 12:11 p.m.

The Executive Session was held under the authority of Section 10-508 of the State-Government Article.

In attendance, in addition to Chairman Colmers, were Commissioners Bone, Jencks, Keane, Loftus, Mullen, and Wong. Commissioners Bone and Mullen participated by telephone.

In attendance representing staff were Donna Kinzer, Steve Ports, Jerry Schmith, Sule Calikoglu, Ellen Englert, and Dennis Phelps.

Also attending were Stan Lustman and Leslie Schulman Commission counsel.

Item One

The Chairman updated the Commission on the status of the State's Model Demonstration Proposal.

Item Two

On motion made the Commissioners voted unanimously to approve a performance bonus for the Acting Executive Director for exemplary work performed to date.

Item Three

Steve Ports, Principal Deputy Director, updated the Commissioners on the status of the recruiting process for various open staff positions.

Item Four

Chairman Colmers updated the Commissioners on potential resources for financial support for future activities related to rate setting based on global budgets.

The Executive Session was adjourned at 12:53 p.m.

MINUTES OF THE
502nd MEETING OF THE
HEALTH SERVICES COST REVIEW COMMISSION

November 6, 2013

Chairman John Colmers called the meeting to order at 1:00 p.m. Commissioners George H. Bone, M.D., Stephen F. Jencks, M.D., M.P.H., Jack C. Keane, Bernadette C. Loftus M.D, Tom Mullen, and Herbert S. Wong, Ph.D. were in attendance.

REMEMBERING SARAH SATTERFIELD

Chairman Colmers noted the passing of Sarah Satterfield, who had previously worked at the Commission for over 20 years as an Administrative Assistant. Ms. Satterfield was a highly valued member of the HSCRC staff.

REPORT OF THE NOVEMBER 6, 2013 EXECUTIVE SESSION

Dennis Phelps, Associate Director-Audit & Compliance, summarized the minutes of the November 6, 2013 Executive Session.

ITEM I
REVIEW OF THE MINUTES OF THE OCTOBER 9, AND OCTOBER 21 EXECUTIVE SESSIONS AND THE MINUTES OF THE OCTOBER 9, 2013 PUBLIC MEETING

The Commission voted unanimously to approve the minutes of the October 9, and October 21, 2013 Executive Sessions. In addition, the minutes of the October 9, 2013 Public Meeting were unanimously approved.

ITEM II
EXECUTIVE DIRECTOR'S REPORT

Ms. Donna Kinzer, Acting Executive Director, reported that Monitoring Maryland Performance (MMP) indicated that the rate of growth in charge per case increased 3.07% for the year ended September 30, 2013, and that inpatient revenue decreased by .67%. Ms. Kinzer stated that for the same period, the number of inpatient cases decreased 3.62%; FY 2013 outpatient revenue increased by 6.55%; and total gross revenue increased by 2.09%. In addition, total gross revenue per capita increased by 1.44%. The total revenue includes revenue for out of state residents.

Ms. Kinzer reported that MMP indicated that the rate of growth in charge per case increased 4.62% for three months ended September 30, 2013, and that inpatient revenue increased by .92%. For the same period, the number of inpatient cases decreased by 3.54%. In addition,

outpatient revenue increased 3.96%, with total gross revenue increasing by 2.13%. Total gross revenue per capita increased by 1.48%. Again, the total revenue includes revenue for out of state residents.

According to the case mix data, total charges for all payers in acute general hospitals increased by 2.15% for fiscal year ended June 30, 2013. Charges for residents of Maryland increased by 1.99% or 1.34% per capita. The proportion of charges for Maryland residents was 90.8% of total charges. The total charges for residents with "Fee for Service" Medicare increased by 2.28% per beneficiary. The change in Medicare charges translates to a reduction in cost per capita after taking in account the estimated 2.9% increase in the over 65 year old population.

According to Ms. Kinzer, for the first three months of fiscal year 2014, the unaudited average operating profits for acute hospitals was 1.19%; the total profit margin for this period was 4.28%; and the median hospital profit was 1.49%, with a distribution of (.78%) in the 25th percentile and 4.02% in the 75th percentile.

Ms. Kinzer reemphasized that unless we are able to incorporate outpatient cases into the Charge per Case approach by January 1st, we will maintain the case mix methodology currently in place, with the usual update process. In addition, we will hold off on reincorporating 0-1 day stay cases until we can incorporate related outpatient cases.

Ms. Kinzer noted that in regard to the 'Two Midnight Rule,' staff solicited input from payers and providers regarding the implementation of the new rule on October 1st and its impact during the month of October. Hospitals reported some logistical issues, but neither hospitals nor payers have had enough experience to report its impact. Staff will solicit input again and report back at the January public meeting.

Ms. Kinzer stated that the hospitals' January 1 rate orders will contain settlements for the year ended June 30, 2013, adjustments for other items that have been deferred, as well as one- time adjustments. Settlements for volume, price, and case mix activity from July 1, 2013 to December 31, 2013 will occur with the July 2014 update.

Ms. Kinzer announced that in November and December, staff will begin discussions with the payment workgroups on modifications to the Maryland Hospital Acquired Conditions (MHAC) and Quality Based Reimbursement (QBR) programs for the rate year 2016.

UPDATE ON NEW ALL-PAYER MODEL FOR MARYLAND IMPLEMENTATION TIMELINE

Ms. Kinzer presented an update on the new All-Payer Model, (see "Update on New All-Payer Model for Maryland Implementation Timeline" on the HSCRC website).

Ms. Kinzer stated that the new all-payer model will focus on improving health care quality, delivery of services, and the affordability of health care. She noted that the new Maryland waiver will focus on overall all–payer hospital expenditures rather than Medicare payment per

admission. The new model includes strong incentives for better outcomes at a lower cost, moving to global and episode reimbursement models with strong incentives for improved quality, and reduction of preventable utilizations and conditions.

Ms. Kinzer noted with the All-Payer Model implementation date scheduled for January 1, 2014, HSCRC staff will focus on the following short term activities:

- Transition Approach with changes in hospital payment models to global models or modified charge per episode
- Reporting and monitoring changes.
- Transitional policies effective January 1
- Meetings of HSCRC and Advisory Council
- Call for white papers and continued planning cycle for work group.
- Work plan for shared savings models with physicians
- Focus on quality and avoidable utilization opportunities
- Preparing January 1 settlement of deferred July adjustments.

Ms. Kinzer announced that the HSCRC has called for white papers and technical papers on 11 topics on its website. The first group of papers will address potential avoidable utilization, methods for monitoring total cost of care, service area/market share, and gain sharing and other physician alignment models. These papers will be due January 10, 2014. The papers will be shared with Commissioners, the Advisory Council and work group members.

ITEM III
DOCKET STATUS CASES CLOSED

2208R - Southern Maryland Hospital Center
2224A- Johns Hopkins Health System
2225A- Maryland Physicians Care
2226A- Johns Hopkins Health System
2227A- MedStar Health
2228A- University of Maryland Medical Center
2229A- University of Maryland Medical Center
2230A- University of Maryland Medical Center
2231A- Johns Hopkins Health System
2232A- Johns Hopkins Health Systems
2233A- University of Maryland Medical Center

ITEM IV
DOCKET STATUS CASES OPEN

2220N- University of Maryland Medical Center

University of Maryland Medical Center (Hospital) filed an application on August 1, 2013 requesting approval of a new rate center for the Trauma Resuscitation Unit (TRU) that will enable outpatient billing for the Shock Trauma Center (STC). The Hospital requested that the new rate center and rate be effective October 1, 2013. The requested rate center and rate will be established in a revenue neutral manner by reclassifying revenue out of the STC Trauma (TRM)

room and board rate center and into the new TRU center.

The Staff recommended:

1) that the Commission approve the new TRU rate at $115.11 per RVU with an effective date of October 1, 2013;
2) that the Admission and TRM rates and STC Charge per Case target be appropriately modified;
3) that the TRU not be rate realigned until a full year's experience has been received by the HSCRC; and
4) that the TRU rate be monitored for 12 months to ensure revenue neutrality.

The Commission voted unanimously to approve staff's recommendation.

ITEM V
FINAL RECOMMENDATION ON CHANGES TO FINANCIAL DATA SUBMISSION

Ms. Ellen Englert, Associate Director of Rate Setting, presented a final recommendation to amend existing regulations regarding monthly financial data submission. (See "Amend Regulation to Change Monthly Financial and Statistical Reporting" on the HSCRC website)

Currently, Maryland hospitals under the jurisdiction of the HSCRC submit monthly financial and utilization data to the HSCRC, per COMAR 10.37.01.03. These monthly reports are filed electronically within 30 days of the last day of the month. The hospital monthly reports are used for a number of purposes including monitoring: 1) financial performance; 2) rate compliance; and 3) the Medicare waiver test.

The HSCRC has begun to implement processes to transition to population based revenue management and cost evaluation. In preparation for the new population based revenue compliance measurement requirement, hospital monthly reporting must separate revenues and volumes for Maryland residents from those outside of the State. In addition, better data are needed for monitoring Medicare revenue trends on a monthly basis. This will require breakouts for Medicare revenues and utilization.

Hospitals that have been referred to traditionally as non-waiver hospitals will be included in the new Medicare test. Thus these hospitals will be required to submit the more comprehensive data needed for the HSCRC to monitor Medicare revenues and utilization.

Ms. Englert stated that hospitals will be required to submit historical data in the revised format for the period between July 1, 2012 and September 30, 2013 by November 15, 2013, and data for the period between October 1st and December 31, 2013 by January 31, 2014.

Therefore, staff proposed an amendment to COMAR 10.37.01.03 as follows:

1. to change the Monthly Reporting Data to include revenue and utilization breakouts for

out of state and Medicare patients in the hospital's monthly reporting effective January 1, 2014;
2. that HSCRC and the hospitals work together to develop monthly breakouts and reconciliations of FY 2013 and Quarters 1 and 2 of FY 2014; and
3. that any facility that believes it cannot meet the reporting deadlines should contact HSCRC staff immediately, in writing. Staff will work with the hospitals to resolve the issues to ensure the statewide data requirements are met.

Anne Hubbard, Assistant Vice President of Financial Policy and Advocacy of the Maryland Hospital Association (MHA), expressed appreciation for the collaborative efforts of the HSCRC staff in the development of the reporting changes, including staff's flexibility with hospitals trying to meet HSCRC deadlines.

The Commission voted unanimously to approve staff's recommendation.

ITEM VI
DRAFT RECOMMENDATION ON UPDATE FACTOR EFFECTIVE JANUARY 1, 2014

Mr. Steve Ports, Principal Deputy Director Policy and Operations, presented a draft recommendation for the continuation of the existing update factor polices through June 30, 2014. (see "Draft Recommendation on Continuation of the Update Factor Approved on June 5, 2013" on the HSCRC website).

Mr. Ports reported that on June 5, 2013, the Commission approved an update factor of 1.65% for inpatient and outpatient services for all regulated hospitals (except private psychiatric hospitals) for a period of July 1, 2013 through December 31, 2013. At the July meeting, the Commission approved an update factor of 1.8% for the private psychiatric hospitals. The June recommendation indicated that the Commission would revisit the update factor for the second half of the year, from January 1, 2014 through June 30, 2014.

However, due to the continued uncertainty associated with the new all-payer model, the status of the current waiver test and the financial condition of hospitals, Staff recommends that the policies adopted by the Commission at the June 2013 meeting be carried forward for the period January 1 to June 30, 2014 as follows:

- continue the update factor of 1.65% (1.8% for psychiatric hospitals) for both inpatient and outpatient services for all regulated hospitals for the period January 1 through June 30, 2014;
- continue with other recommendations made on June 5, 2013 and rate settlements until modified; and
- continue to monitor federal changes that might affect Medicare payments.

Commissioner Mullen asked whether staff had considered cuts resulting from the federal

sequester and recent increases in inflation in its recommendation to continue with the update factor.

Mike Robbins, MHA Senior Vice President, Financial Advocacy and Policy pointed out that hospitals continue to have financial challenges and still have not had a significant turnaround in financial stability despite the 1.65% and 1.8% update increases. Mr. Robbins recommended that hospital financial status be considered in any white papers submitted to the Commission to ensure that the financial stability of the hospitals is included in any new policies implemented.

Gary Simmons, Regional Vice President, United Healthcare, and John Hamper Director of Provider Reimbursement, CareFirst Inc., both spoke in support of the staff recommendation.

As this is a draft recommendation, no Commission action is necessary at this time.

ITEM VII
DRAFT RECOMMENDATION ON FUTURE FUNDING SUPPORT FOR THE CHESAPEAKE REGIONAL INFORMATION SYSTEM FOR OUR PATIENTS (CRISP)

Mr. Ports and David Sharp, Director of the Maryland Health Care Commission's Center for Health Information Technology, presented a draft recommendation for continued funding support for the Chesapeake Regional Information System for our Patients (CRISP) (see, "Draft Recommendation for the Chesapeake Regional Information System for our Patients" on the HSCRC website).

The purpose of the draft recommendation is to recommend continued funding for CRISP, Maryland's designated Health Information Exchange (HIE), for the period FYs 2015 through 2019.The funding amount will assist CRISP in fulfilling its role in implementing the HIE and health care reform in Maryland. As the State's HIE, Staff views CRISP as a critical partner as they begin to track utilization across care settings and implement per capita and population-based payment methodologies.

The Maryland Health Care Commission and HSCRC recommended funding of up to $1.5 million annually through Maryland's unique all-payer hospital rate setting system to CRISP over the next 5 years (FYs 2015 – FY 2019) to support the continued development and use of the State-Designated HIE. The continued funding is necessary to meet the anticipated uses of health information exchange, as well as the needs of the HSCRC under the new All-Payer Model Design the funding will also be utilized for quality measurement and improvement such as monitoring and reducing readmissions across the State.

Chairman Colmers reminded the Commission that CRISP funding comes from limited hospital resources. He recommended that other resources, including those of other healthcare entities that benefit from CRISP, also contribute a fair share of their revenue in the future.

As this is a draft recommendation, no Commission action is necessary at this time.

ITEM VIII
REPORT ON FY2014 UNCOMPENSATED CARE POLICY AND DRAFT RECOMMENDATION REGARDING CHARITY CARE ADJUSTMENT

Mr. Nduka Udom, Associate Director, Research and Methodology, presented a report on the results of the Uncompensated Care Policy and the draft recommendation to change the formula for calculating the hospital specific results (see, "Report on Results of Uncompensated Care Policy and Draft Recommendation to Change the Formula for Calculating the Hospital Specific Results" on the HSCRC website). Mr. Udum pointed out three corrections to the Report: the first on page 1 incorrectly reads, "The most recent version of the policy was adopted by the Commission on September 1, 2010." With the correction it should read, "The most recent version of the policy was adopted by the Commission on July 6, 2012." The second correction also on page 1, incorrectly reads, "The proportion of a hospital's total charges from outpatient Medicaid, self-pay, and charity visits to the emergency room; and…" With the correction it should read, "The proportion of a hospital's total charges from outpatient non-Medicare emergency department charges; and …" The third correction on page 2 incorrectly reads, "The proportion of a hospital's total charges from outpatient charges." With the correction it should read, "The proportion of a hospital's total charges from outpatient Medicaid, self-pay, and charity visits."

Based on this Report, staff recommended that the Commission suspend the Charity Care Adjustment for FY2014 until an alternative Charity Care Adjustment methodology is developed and approved. A final recommendation will be brought to the Commission at the December 2013 meeting

As this is a draft recommendation, no Commission action is necessary at this time.

ITEM IX
LEGAL REPORT

Regulations

Proposed and Emergency

Monthly Reports of Achieved Volumes and Revenues - COMAR 10.37.01.03

The purpose of this action is to require hospitals, beginning January 1, 2014, to include revenue and utilization break outs for out of state and Medicare patients in the monthly reporting. Additionally, the data shall be submitted in a manner and format prescribed by the Commission and as described on the Commission's website.

The Commission voted unanimously to forward the proposed regulation to the AELR Committee for review and publication in the Maryland Register both as a proposed and emergency regulation.

COMAR 10.37.01.02

The purpose of this action is to update the Commission's "Accounting and Budget Manual for Fiscal and Operating Management" (August 1987), which has been incorporated by reference.

The Commission voted unanimously to forward the proposed regulation to the AELR Committee for review and publication in the Maryland Register as a proposed regulation.

HEARING AND MEETING SCHEDULE

December 4, 2013	Time to be determined, 4160 Patterson Avenue, HSCRC Conference Room
January 9, 2014	Time to be determined, 4160 Patterson Avenue, HSCRC Conference Room

There being no further business, the meeting was adjourned at 2:48 p.m.

EXECUTIVE DIRECTOR'S REPORT
DECEMBER 4, 2013

Monitoring Maryland Performance

For Twelve Months Ended October 2013:

- Charge per Case increased 3.86%
- Cases (admissions + new born) decreased (3.65%)
- Inpatient revenue increased 0.07%
- Outpatient revenue increased 6.05%
- Total gross revenue increased 2.38%

For Four Months Ended October 2013 versus the same time period in last year:

- Charge per Case increased 5.55%
- Cases (admissions + new born) decreased (3.72%)
- Inpatient revenue increased 1.62%
- Outpatient revenue increased 5.58%
- Total gross revenue increased 3.19%
- Total gross revenue per capita increased by 2.53% but this does not exclude revenues for out of state residents.

Financial Condition

Data are available for profits for the first three months of FY 14 (July through October 2013). For this year to date period, average operating profits for all acute care hospitals was 1.54 percent. The total profit margin for this period is 4.69 percent. The median hospital had an operating profit of 1.95 percent, with a distribution as follows:

- 25th percentile at -0.12%
- 75th percentile at 4.20%

Change in Commission Meeting Date

The HSCRC staff will seek a change in the dates of Commission meetings. We will aim to hold the meeting later in the month, to allow additional time for staff review of monthly monitoring reports.

Progress on the Application for the Maryland's All-Payer Model

The Governor submitted the State's updated application to the Center for Medicare & Medicaid Innovation on October 11, 2013.
http://dhmh.maryland.gov/SitePages/Medicare%20Waiver%20Modernization.aspx
Implementation activities are in process for a proposed start date of January 1, 2014.

Implementation Steps for All-Payer Model

Hospital data submission for monitoring: Most hospitals have submitted historical monthly financial data breaking out revenue from residents and non-residents and Medicare from all payer data for the 18 months ended September 30. Staff is performing audits of the data, since it will form the basis of monitoring under the All Payer model.

Transitional implementation policies: Interim policies relative to implementation of proposed All-Payer model will be introduced at the January HSCRC meeting. These will include interim changes to variable cost policies, payment model approaches, and other policy changes.

Advisory Council Update: Advisory Council meetings have begun and an initial report is expected at the end of January

Transition activities: In the short term, HSCRC staff are focused on the following activities

- Transition Approach with changes in hospital payment models to global models or modified charge per episode
- Monitoring changes
- Transitional policies effective January 1
- Meetings of HSCRC and Advisory Council
- Call for white papers and continued planning cycle for work groups
  http://www.hscrc.state.md.us/documents/md-maphs/hscrc-call-for-papers-2013-10-25.pdf
- Work plan on shared savings models with physicians
- Focus on quality and avoidable utilization opportunities
- January 1 settlement of deferred July adjustments

Priorities after January 1: The HSCRC staff will establish priorities for activities after January 1, with input from the Commissioners, Advisory Council, and workgroups

- Rate and Revenue update Process for Year 1
  - July 1, 2014 Update
  - New Germantown hospital revenue sources under new all-payer model
  - Market share approach
  - Trending/inflation/population adjustments
  - Potentially avoidable utilization
  - Value-based payments
  - Combine IP and similar OP case (for CPE and efficiency measures)
  - 12/31/2013 settlements
  - Uncompensated care model changes
- Initiate Work Groups

  - Staff will prioritize workgroup activities and appoint workgroups to focus on priority tasks
- Monitoring and Contract Compliance

Other Activities

Charge per case update: HSCRC staff is working on incorporating both inpatient and outpatient activity into the new charge per case approach. While this update will not be ready for January 1, it should be ready for review early in 2014.

Two-midnight rule: We will solicit input for our January HSCRC meeting on implementation progress.

MHAC and QBR Updates: QBR/MHAC Updates for Rate Year 2016: Since the performance periods for Rate Year 2016 start in Calendar Year 2014, staff is presenting modifications to the methodologies that will be effective with the new performance periods. Because the new All Payer Model may create different priorities, and staff will have more timely case mix data, these policies will be supplemented and may be modified.

Establishment of New Rate Centers: HSCRC accepts applications from hospitals that are establishing new rate centers. New rate centers and services will need to be funded out of population adjustments and other available mechanisms consistent with the proposed All Payer model. Hospitals will need to recognize the need to fund all projects within the per capita ceiling requirements.

Uncompensated Care Adjustment: The annual filings for 2013 show an increased level of uncompensated care. We are estimating that the total for FY 2013 (after including estimates for 12/31 hospitals) will be about 7.3%. This is above the 6.85% now funded in rates. Effective 1/1/2014, Medicaid will expand, reducing uncompensated care. As a result, we will need to update the uncompensated care models to reflect the increase in actual uncompensated care as well as the decreases from the expansion. The target effective date is July 1, 2014. Additionally, as previously noted, much care for undocumented immigrants will not be covered by the Medicaid expansion. (Currently, Medicaid covers OB care and emergency care when undocumented immigrants are deemed eligible). HSCRC staff anticipates that the formula will change to give better recognition to the impact on uncompensated care of non-covered populations as well as adjusting for levels of uncompensated care.

All Payer Hospital System Modernization Advisory Council
Status Report; 11/25/13

Introduction

This document serves as the first status report from the All Payer Hospital System Modernization Advisory Council (Advisory Council) to the Health Services Cost Review Commission (HSCRC).

Advisory Council Activity

HSCRC Kickoff Meeting

The Advisory Council convened in a joint session with the HSCRC on November 13, 2013. At that meeting the Council heard presentations on the Proposed Model Application, implementation goals and challenges, and the HSCRC's charge to the Council.

First Meeting of the Advisory Council

The first meeting of the Advisory Council was held on November 21, 2013. During the session, the Council heard presentations on the new model performance requirements, and staff proposed short-term, mid-term and long-term implementation priorities as well as ranking criteria for successful implementation. The Council also discussed the high level objectives of its final report which are to provide the following three items:

1. Stakeholder Priorities for Implementation Phasing
2. Guiding Principles for Ensuring Successful Implementation
3. Recommended Areas for Work Group Focus.

In its discussion of priorities and guiding principles, the Council began to define critical issues that must be addressed, and how it's recommendations to the Commission should be organized. There were emerging areas of consensus on some of the issues discussed, and the Council made good initial progress on developing an organizational framework for setting implementation priorities and guiding principles. This early progress will be explored in more depth at the next Council meeting as the Council reaches more consensus and specificity regarding these priorities and guiding principles.

The Council also received a staff document outlining the schedule of meetings and deliverables which will lead to the completion of the final report (see below). This provides a high level work plan for meetings to be held over the next two months.

Advisory Council Meeting Schedule/ Workplan

Date	Meeting Products
November 21, 2013 10-12	1.Advisory Council Schedule and Work Plan 2. Advisory Council Report Objectives

Sheraton Town Hall Center Columbia, MD	3. Initial discussion of implementation priorities and guiding principles. **Follow Up:** Council members to share their thoughts on potential guiding principles and implementation priorities with Council staff via email. Council staff will provide additional information to members on issues that were raised during the meeting, including gainsharing models, and a webinar to review the model proposal.
December 12, 2013 10-12 HSCRC Conference Room 100	1. Initial draft of Consensus Guiding Principles; Comments on areas still under discussion. 2. Initial draft of Implementation Phasing Priority recommendations; Comments on areas still under discussion. 3. Initial draft of recommendations for Work Group focus. **Follow-up:** Council Staff will circulate draft of the status report outlining the 3 items above, for Council Member review and comment.
January 9, 2014 (Tentative) 10-12 HSCRC Conference Room, 100	1. Final Consensus on Guiding Principles, and comments on areas where there is still disagreement. 2. Final Consensus on implementation phasing priorities, and comments on areas where there is still disagreement. 3. Final recommendations on issues to be considered by the Work Groups. **Follow-up:** Council Staff will circulate a draft of the final report for review and comment
January 23, 2014 (Tentative) 10-12 Location: TBD	1. Council Final Recommendations on: a) Guiding Principles for Implementation b) Stakeholder Priorities for Implementation Phasing and Project Plan c) Issues for Workgroup consideration.

Report Due Dates	
December 4, 2013	Status Report - Provide work plan for Advisory Council
December 30, 2013	Status Report- Provide update on Advisory Council Work
January 27, 2014	Final Report – Recommendations

Public Comment and Feedback

The Advisory Council is reserving time at the end of each of its meetings for the public in attendance to make brief comments or ask questions. Additionally, the public is being encouraged to submit comments on the Council's work via email to hscrc.stakeholders@maryland.gov. Comments received have been posted on the Advisory Council's webpage on the HSCRC website and can be found at the

following link: http://www.hscrc.state.md.us/hscrc-advisory-council.cfm. To date the Council has received comments and recommendations from one organization, the Maryland Women's Coalition for Health Care Reform. In addition to the public comments received, the Advisory Council website also includes links to meeting agendas, presentations and will include links to meeting notes/minutes.

Advisory Council Status

The Advisory Council is currently on track to complete its final report to the HSCRC by the end of January. The Council is clear on its charge, and is working to complete it. The Advisory Council understands that Work Groups are being convened in the beginning of 2014 to discuss technical aspects of implementation in detail, and that the Council will reconvene during the Work Group process to hear updates on Work Group progress, and to provide feedback to the HSCRC on Work Group findings and reports.

As the Advisory Council process continues, the HSCRC will be notified of any major issues, questions, and/or identified barriers which could impact the Council's completion of its charge.

Request for Extension of Approval
Proceeding 2182A
John Hopkins Health System

Staff Recommendation
Approved
December 4, 2013

Background

On July 28, 2013, in accordance with the authority granted by the Commission staff approved a 3 month extension of the Commission's approval of the alternative rate arrangement between the Johns Hopkins Health System (JHHS) and Cigna Health Corporation, Proceeding 2182A. The extension expires on December 31, 2013. However, JHHS and Cigna have not completed negotiations to extend the arrangement.

Request

JHHS requests that the Commission extend its approval for an additional month, to January 31, 2014, to complete negotiations.

Findings

Staff found that the experience under the current arrangement has been favorable.

Staff Recommendation

Staff recommends that the Commission grant JHHS's request for a one month extension of its approval, with the condition that if the negotiations are not completed before the expiration of this extension that the arrangement end and that no further services be provided under the arrangement until a new application is approved.

IN RE: THE PARTIAL RATE	*	**BEFORE THE HEALTH SERVICES**
APPLICATION OF	*	**COST REVIEW COMMISSION**
PENINSULA REGIONAL	*	**DOCKET: 2013**
MEDICAL CENTER	*	**FOLIO: 2044**
SALISBURY, MARYLAND	*	**PROCEEDING: 2234N**

Staff Recommendation

Approved

December 4, 2013

Introduction

On November 4, 2013, Peninsula Regional Medical Center (the "Hospital") submitted a partial rate application to the Commission requesting a rate for Psychiatric Day/Night (PDC) services. The Hospital requests that the PDC rate be set at the lower of a rate based on its projected costs to provide PDC services or the statewide median and be effective January 1, 2014.

Staff Evaluation

To determine if the Hospital's PDC 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 all projected cost and statistical data for PDC services for FY2014. Based on information received, it was determined that the PDC rate based on the Hospital's projected data would be $418.10 per visit, while the statewide median rate for PDC services is $389.47 per visit.

Recommendation

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

1. That a PDC rate of $389.47 per visit be approved effective January 1, 2014;
2. That no change be made to the Hospital's Charge per Episode standard for PDC services; and
3. That the PDC rate not be rate realigned until a full year's cost experience data have been reported to the Commission.

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IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION	*	**COMMISSION**	
JOHNS HOPKINS HEALTH	*	**DOCKET:**	**2013**
SYSTEM	*	**FOLIO:**	**2045**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2235A**

Staff Recommendation

Approved

December 4, 2013

I. INTRODUCTION

Johns Hopkins Health System (the System) filed a renewal application with the HSCRC on November 20, 2013 on behalf of its member hospitals, the Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, and Howard County General Hospital (the Hospitals) for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System requests approval from the HSCRC for continued participation in a capitation arrangement serving persons insured with Tricare. The arrangement involves the Johns Hopkins Medical Services Corporation and Johns Hopkins Healthcare as providers for Tricare patients. The requested approval is for a period of one year beginning January 1, 2014.

II. OVERVIEW OF APPLICATION

The parties to the contract include the Johns Hopkins Medical Services Corporation and Johns Hopkins Healthcare, a subsidiary of the System. The program provides a range of health care services for persons insured under Tricare including inpatient and outpatient hospital services. Johns Hopkins Health Care will assume the risk under the agreement, and the Hospitals will be paid based on their approved HSCRC rates.

III. STAFF EVALUATION

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

IV. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' renewal application for an alternative method of rate determination for a one year period beginning January 1, 2013. 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:**	**2013**
SYSTEM	*	**FOLIO:**	**2046**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2236A**

Staff Recommendation

Approved

December 4, 2013

I. INTRODUCTION

On November 21, 2013, 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 to continue to participate in a revised global price arrangement with Life Trac (a subsidiary of Allianz Insurance Company of North America) for solid organ and bone marrow transplants and cardiovascular services. The Hospitals request that the Commission approve the arrangement for one year beginning January 1, 2014.

II. OVERVIEW OF APPLICATION

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

III. FEE DEVELOPMENT

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

IV. IDENTIFICATION AND ASSESSMENT RISK

The Hospitals will continue to submit bills to JHHC for all contracted and covered services. JHHC is responsible for billing the payers, 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 that 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

The staff found that the actual experience under the arrangement for solid organ and bone marrow transplants for the last year has been favorable.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for solid organ and bone marrow transplant services for the period beginning January 1, 2014. 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 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:**	**2013**
SYSTEM	*	**FOLIO:**	**2047**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2237A**

Staff Recommendation

Approved

December 4, 2013

I. INTRODUCTION

On November 21, 2013, Johns Hopkins Health System ("System") filed a renewal application on behalf of its member hospitals (the "Hospitals") requesting approval from the HSCRC to continue participation in a revised global rate arrangement for cardiovascular procedures with Global Excel Management, Inc. The Hospitals request that the Commission approve the arrangement for an additional year beginning January 1, 2014.

II. OVERVIEW OFAPPLICATION

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 ASSESSMENTOF RISK

The Hospitals will continue to submit bills to JHHC for all contracted and covered services. JHHC is responsible for billing the payer, collecting payments, disbursing payments to the Hospitals at their full HSCRC approved rates, and reimbursing the physicians. The System contends that the arrangement among JHHC, the Hospitals, and the physicians holds the Hospitals harmless from any shortfalls in payment from the global price contract. JHHC maintains it has been active in similar types of fixed fee contracts for several years, and that JHHC is adequately capitalized to bear the risk of potential losses.

V. STAFF EVALUATION

Staff found that there was no experience under the arrangement for the last year. However, staff believes 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 cardiovascular services for a one year period commencing January 1, 2014. The Hospitals will need to file a renewal application for review to be considered for continued participation. Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospitals for the approved contract. This document would formalize the understanding between the Commission and the Hospitals, and would include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.

Final Recommendation on Continuation of the Update Factor Approved on June 5, 2013

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

December 4, 2013

This document contains the final recommendations for continuation of the existing update factor policies through June 30, 2014. These final recommendations were unamiously approved by the Commission at the December 4, 2013 meeting.

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A. Introduction

On June 5, 2013, the Commission approved an update factor of 1.65% for inpatient and outpatient services for all regulated hospitals (except private psychiatric hospitals) for the period of July 1, 2013 through December 31, 2013. At its July meeting, the Commission approved an update factor of 1.8% for the private psychiatric hospitals. The June recommendation indicated that the Commission would revisit the update factor for the second half of the year, from January 1, 2014 through June 30, 2014. The HSCRC staff is recommending that the update factors previously approved be continued at the same levels for the second six months of the year, from January 1 through June 30, 2014.

The rationale for the six month review period was that there continued to be uncertainty associated with several factors, including the status of a new all-payer model being discussed with the Center for Medicare & Medicaid Innovation, the status of the current waiver test, and the financial condition of hospitals. Based on the various continuing uncertainties, the HSCRC staff is recommending that the Commission retain the same approved update factors through the year ending June 30, 2014.

The Commission adopted a total of six recommendations to implement the July 1, 2013 update, including deferral of other rate adjustments and settlements for the June 30, 2013 year end until January 1, 2014. This allowed the HSCRC staff to issue rate orders by July 1, 2014 reflecting the 1.65% update factor and to prepare for a "stub period" reconciliation and rate adjustments for a new rate period beginning January 1, 2014. The HSCRC staff is not recommending any changes to these adopted policies.

To facilitate review, the recommendations adopted by the Commission in June 2013 are as follows:

Recommendation 1: Apply an update factor of 1.65 percent [1.8 percent for psychiatric hospitals] to both inpatient and outpatient rates of all hospitals for which the Commission sets rates for a stub period of July 1, 2013 through December 31, 2013; and revisit the update factor for the period January 1, 2014 through June 30, 2014 taking into consideration, among other things, the status of the model design application and related implications (such as aggregate spending), factor cost, the waiver cushion, and financial condition.

Recommendation 2: Apply all adjustments and assessments for FY 2014 on January 1, 2014 in a manner that would have the full annual impact for the Fiscal Year.

Recommendation 3: Apply Shared Savings on January 1, 2014 in a manner that would achieve the full savings from the program in FY 2014.

Recommendation 4: Permanently Eliminate the One Day Stay Case Mix Adjustment

Recommendation 5: Continue reallocation of the inpatient revenue for FY2014

Recommendation 6: No ROC Scaling for FY2014

B. New Framework for All Payer Model Design

On October 11, 2013, the State submitted a revised application to the Center for Medicare & Medicaid Innovation (CMMI) to establish a framework in which the revenue controls employed- by the HSCRC would shift from the current focus on controlling increases in revenue per inpatient case and per outpatient service to a focus on controlling increases in total hospital revenues within an all-payer cap, to generate savings for the Medicare program, and to achieve a range of improvements in quality and outcomes.

The revised application proposes an implementation date of January 1, 2014. Review of the application is in process, and the HSCRC has begun implementation activities. Transitional implementation policies are under development and will be reviewed at upcoming HSCRC meetings.

C. Market Basket and Medicare IPPS and OPPS Rules

In June, the Commission adopted an update factor which was constructed in the following manner:

Market Basket:	2.31%
Policy adjustments	-.66%
Net Update Factor	**1.65%**

The basis for this decision was the projected market basket provided in the first quarter Global Insights book for FY 2014 of 2.31%. The second quarter book for FY 2014 projects a small increase in the market based to 2.41%.

CMS used a slightly higher market basket of 2.50%, as shown below, but made a number of adjustments. In August, CMS adopted the IPPS payment update for FY 2014. The final rule made the following changes to Medicare reimbursement for inpatient services:

Market Basket:	2.50%
Productivity:	-0.50%
ACA:	-0.30%
Documentation and Coding:	-0.80%
DSH Reductions:	-0.40%
Total Update:	**0.50%**

In July, CMS released its proposed rule for the FY 2014 OPPS payment update. A final rule is anticipated sometime in December. The proposed rule would make the following changes:

Market Basket:	2.50%
Productivity:	-0.40%
ACA:	-0.30%
Total Update:	**1.80%**

Evaluation of the IPPS and OPPS updates is important because the updates either affect the current waiver test or the Medicare savings requirements proposed in the application to CMMI for the new All-

Payer model. HSCRC uses a different approach to controlling the impact of documentation and coding on case mix growth through its case-mix governor. Excluding this adjustment of -.8%, the IPPS inpatient update was 1.3%.

Considering the modest change in market basket and the current state of IPPS and OPPS payment levels, the HSCRC staff finds no reason to change its June recommendation.

D. Findings and Recommendations

When adopting the update factor for the period July 1, 2013 through December 2013, the Commission found considerable uncertainty regarding:

- The potential for an alternative waiver model;
- Waiver projections;
- Potential adjustments to the waiver calculations related to national payments;
- The potential impact of the final Inpatient Prospective Payment System (IPPS) rule; and
- The financial condition of hospitals.

While the IPPS update has been finalized, the federal environment continues to create uncertainty and continued concerns regarding financial results of hospitals remain. The State's updated application for a new All-Payer Model is under review by CMMI, and the HSCRC is preparing for implementation based on a requested effective date of January 1, 2014. In sum, the Commission continues to face uncertainties as it prepares for transition to a new All-Payer model. Therefore, staff recommends the following:

- Continue the existing update factor of 1.65% for all hospitals except private psychiatric hospitals and 1.8% for private psychiatric hospitals through June 30, 2014.
- Continue with other recommendations made in June and rate settlements until modified.
- Continue to monitor federal changes that might affect Medicare payments.

Final Recommendation for Continued Funding Support for the Chesapeake Regional Information System for our Patients (CRISP)

December 4, 2013

This final recommendation follows the draft recommendation made by the staffs of the Maryland Health Care Commission & Health Services Cost Review Commission at the Commission's November 6, 2013 public meeting. This final recommendation was unamiously approved by the Commission at the December 4, 2013 meeting.

CRISP State Designated Health Information Exchange

Funding Request

Overview

The purpose of this staff report is to recommend continued funding for CRISP, Maryland's designated Health Information Exchange, for the period FY 2015 through FY 2019. The funding amount will assist CRISP in fulfilling its role in implementing the Health Information Exchange and health care reform in Maryland.

In the August 2013 HSCRC meeting, HSCRC staff presented its recommendation for funding through 2014. Representatives of CRISP also reported on its current status, its activities in health care reform in Maryland, and its accomplishments in the Health Information Exchange. More information on CRISP, including its interaction with HSCRC, is included in the Appendix to this document.

In July of this year, the staff of HSCRC and the Maryland Health Care Commission (MHCC) met several times with CRISP and reviewed the scope of its activities and its financial progress since its inception. Since August, HSCRC and MHCC staff have had additional meetings to review current funding requirements for CRISP. The recommendations presented in this report are based on those reviews.

CRISP's Role and History of Funding

The value of a health information exchange (HIE) rests in the promise that more efficient and effective access to health information will improve care delivery while reducing administrative health care costs. The General Assembly, in Health-General Article §19-143, charged the MHCC and the HSCRC with the designation of a statewide HIE. In the summer of 2009, MHCC awarded State-Designation to the Chesapeake Regional Information System for our Patients (CRISP), and the HSCRC approved up to $10 million in startup funding over a four-year period through Maryland's unique all-payer hospital rate setting system. HSCRC-funding by year is illustrated in the table below.

CRISP Budget: HSCRC Funds Received	
FY 2010	$4,650,000
FY 2011	No funds received
FY 2012	$2,869,967
FY 2013	$1,313,755
FY 2014	$1,166,278
Total	**$10 Million**

The use of HIEs is a key component of health care reform, enabling clinical data sharing among appropriately authorized and authenticated users. The ability to exchange health information electronically in a standardized format is critical to improving health care quality and safety.

Many states and federal policy makers consider Maryland a leader in HIE implementation. Further investment in building CRISP's infrastructure is necessary to support existing and future use cases and to assist the HSCRC as it moves to more per-capita and population-based payment structures. A return on the investment will occur from having implemented a robust technical platform that can support innovative use cases to improve care delivery, increase efficiencies in health care, and reduce health care costs.

CRISP'S Role With HSCRC

In addition to its role in health information exchange among providers, CRISP is involved in health care reform activities related to the HSCRC, MHCC, DHMH, and other state agencies. The HSCRC derives significant benefit from the enterprise master patient index (EMPI). This index is developed using highly sophisticated tools from secure electronic submission to CRISP of registration data from hospitals. The EMPI allows for accumulation of use across hospitals, which HSCRC uses to track readmissions across hospitals. CRISP is also working with HSCRC and providers to develop information that can be used for new payment models based on patient attribution to hospitals. The information can also be used to help develop effective approaches to care management and physician pay for performance. Additionally, CRISP and HSCRC are working to use this information along with enrollment data to help track use of services in aggregate for individuals obtaining Medicaid or other insurance coverage under health care reform.

Staff Recommendation

The staffs of MHCC and HSCRC recommend funding of up to $2.5 million annually through Maryland's unique all-payer hospital rate setting system to CRISP over the next five years (FYs 2015 – FY 2019) to support the continued development and use of the State-Designated HIE. The continued funding is necessary to meet the anticipated uses of health information exchange as well as the needs of the HSCRC under the new All-Payer Model Design. The funds will also be used for quality measurement and improvement such as monitoring and reducing readmissions across the State. It should be recognized that under this new All-Payer Model Design any additional funds (over the previous year) designated to assessments such as this will offset any annual amounts available for growth under an all-payer growth ceiling.

The funding can also be used to leverage federal fiscal participation (90/10 match requirement) under the Health Information Technology for Economic and Clinical Health (HITECH) Act. HITECH enables states to be approved for funding by CMS under the Medicaid EHR Incentive Program and receive a 90 percent federal financial participation match for expanding HIE through 2021. In order to access such matching funds, the funding mechanism must be uniform and broad-based across all hospitals. Therefore, the HSCRC would need to change the current

practice of imposing the assessment on a few hospitals to apply to all regulated acute care hospitals in the State.

HITECH funding is based on a state's overall financial plan that leverages multiple funding sources to develop and maintain HIEs between hospitals, health systems and individual practices. All combined, based on the Medicaid/ DHMH submission of the required Implementation Advanced Planning Document (IAPD) application, CMS approved approximately $6.2M of matching funds under HITECH for HIE development in fiscal years 2013 and 2014 using funding through DHMH. While this funding is not available in FY 2015, other matching funds are available as outlined above.

The annual funding to CRISP, including both the amount received through rates and any IAPD matching funds, will be determined by an annual MHCC and HSCRC combined staff evaluation. The proposed $2.5 million is considered a cap and staff does not anticipate granting the full amount each year. The amount received each year will be based upon CRISP achieving performance goals established annually by the CRISP Board of Directors, as well as performance on select activities requested by MHCC and HSCRC. HSCRC and MHCC will continue to review the sustainability of CRISP under multiple sources of funds from HSCRC fees, grants, user fees, and other revenue sources.

Appendix

OVERVIEW OF CRISP--HISTORY, GOVERNANCE, AND OPERATIONS

History and Purpose

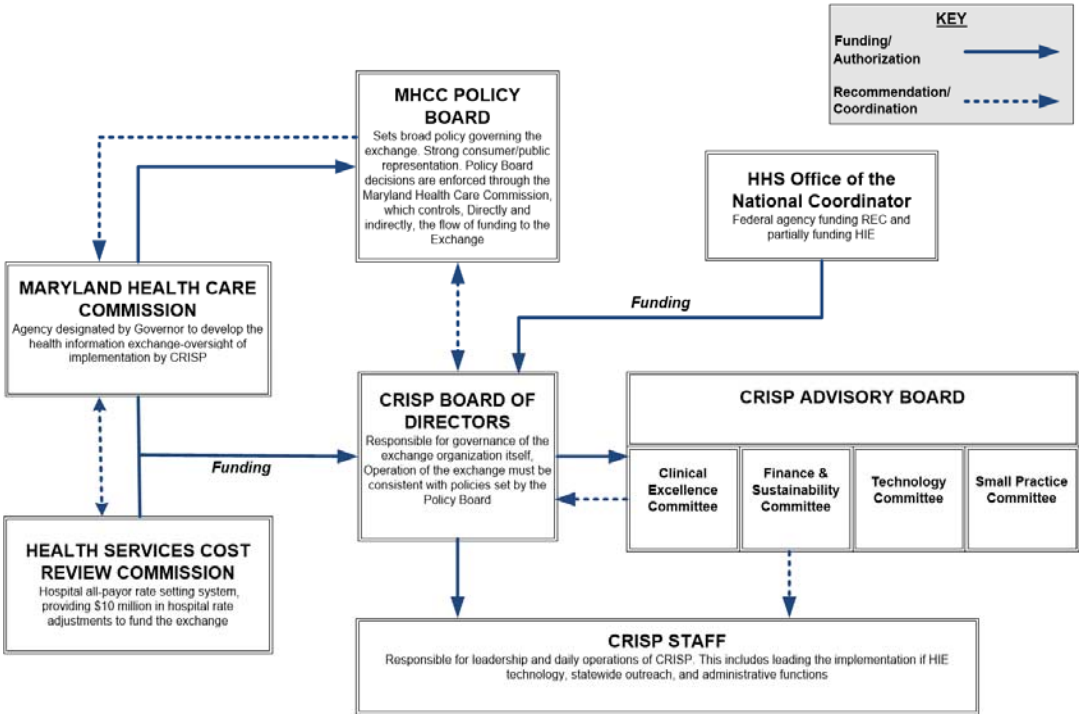
The MHCC is the State agency responsible for advancing health information technology throughout Maryland. In 2005, MHCC initiated the development of guiding principles for an interoperable and secure statewide clinical data sharing utility, or HIE. In 2007, MHCC and HSCRC proposed a two-phase strategic plan consisting of different parallel planning projects, followed by a single implementation project to build a statewide HIE. The purpose of the planning phase was to bring together two distinct groups of diverse stakeholders who would address complex policy and technology issues from different perspectives. The two multi-stakeholder groups selected to participate in the planning phase were: CRISP and the Montgomery County Health Information Exchange Collaborative. Final reports of the planning phase were submitted by each group in February of 2009.

In April 2009, MHCC issued a competitive Request for Application (RFA) for designation as the State-Designated HIE. Several months later, after a thorough evaluation by a national review team, MHCC and HSCRC designated CRISP as the State-Designated HIE. The MHCC and CRISP entered into a three-year Memorandum of Understanding (MOU) on October 29, 2009 that incorporated the terms of CRISP's RFA, which was the basis for its designation as the State-Designated HIE. The MHCC renewed the MOU for a second three-year timeframe on March 11, 2013.

The MHCC and HSCRC have worked to assure continued progress in the electronic exchange of health information by both community-based HIEs and the State-Designated HIE. To further the efforts to build out the State-Designated HIE, MHCC wrote grant applications that resulted in the award of two grants totaling $10.6 million by the federal Office of the National Coordinator (ONC), for the development of a statewide HIE for Maryland. The MHCC has also successfully collaborated with CRISP and the Department of Health and Mental Hygiene (DHMH) in obtaining other significant HIE grants in Maryland.

State Designated HIE – CRISP Governance Structure

CRISP is an independent non-stock Maryland membership corporation, qualified as tax-exempt under Section 501(c)(3) of the Internal Revenue Code. Founding members of CRISP include: the Johns Hopkins Health System; MedStar Health; University of Maryland Medical System; Erickson Retirement Communities; and Erickson Foundation. The CRISP Board of Directors consists of nine appointees of the original members, two payer representatives, two Secretary of DHMH appointees, two community representatives, and two small physician practice representatives. In addition, MHCC and HSCRC staff, along with more than two dozen major stakeholders across the State, participate on various CRISP advisory boards.



Key Accomplishments

The State-Designated HIE is responsible for building and maintaining the technical infrastructure that can support electronic health information exchange. Since its initial designation, CRISP has been successful in accomplishing significant milestones in implementing a statewide HIE. For nearly five years, the State-Designated HIE has made continuous progress towards the goal of building a robust and interoperable HIE, while also supporting provider adoption of electronic health records (EHRs), educating physicians on meaningful use and the State regulated payer EHR adoption incentive program, and providing clinical encounter reporting capabilities to participating providers.

The State-Designated HIE is envisioned to eventually support a basic level of interoperability to communicate authenticated EHR systems data among providers. The State-Designated HIE will also enable communities with service area HIEs to connect to other communities around the

State and, in the future, with providers in other states. During its initial three-year State designation, CRISP has shown both a commitment to the objectives set forth in State law for the development of HIE and the technical ability to achieve those objectives.

Milestones

The State-Designated HIE has made considerable progress in achieving critical milestones. These milestones have enabled CRISP to provide value to providers and patients statewide. The milestones listed below are considered by MHCC and HSCRC staff as noteworthy achievements over the last several years.

Key Statewide HIE Accomplishments	
Activity	**Date**
All 46 Maryland acute care hospitals signed letters of intent to connect to the State-Designated HIE within two years and went live with five hospitals in Montgomery county, two national laboratories, and three national radiology centers	September 2010
CRISP launched query portal pilot	March 2011
All 46 Maryland acute care hospitals were connected to the statewide HIE providing admission, discharge, and transfer data	December 2011
CRISP launched Direct Secure Messaging service	July 2012
CRISP launched Encounter Notification Service	August 2012
Maryland Medicaid received CMS Medicaid 90/10 funding for HIE related services	November 2012
Query portal reached 10,000 queries per month	January 2013
100 organizations have adopted the query portal	March 2013
Identities in the Master Patient Index (MPI) reached 5 million	May 2013

Several of these accomplishments will be instrumental in permitting the HSCRC to evaluate per-capita and population-based based payment structures and performance. The HSCRC continues to work with CRISP on projects that will allow tracking of readmissions across hospitals, and understanding the impact that the Affordable Care Act may have on hospital uncompensated care in Maryland. Appendix I illustrates the framework that has been employed to accomplish this type of tracking in the near term.

HSCRC intends to work with CRISP to enhance readmission reports to hospitals that will be helpful in monitoring and reducing readmissions.

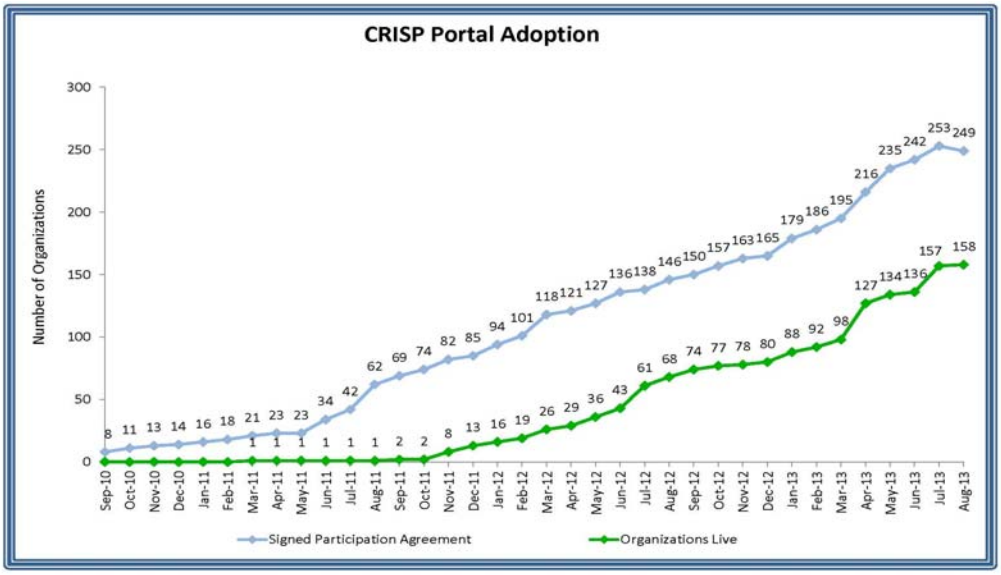
Annual Performance

The volume of information made available through the State-Designated HIE has continued to increase over the last year. Value of the HIE is directly tied to the amount of patient information that is available to providers when they access CRISP. The rate of growth is notable in each metric category.

Metric	12-Aug	13-Aug
Live hospitals – acute care hospitals	46	46
Live clinical data feeds	55	98
ADT submission (# of hospitals)	46	46
Participating physicians (query & notification)	~129	~1,200
Unique patient identities in MPI	~2.8M	~5.6M
ENS notifications (# generated)	108	70,056
ENS notifications (past 30 days)	-	~34,000
Live labs and rad centers (non-hospital)	5	9
Laboratory results submission (# of hospitals)	25	31
Lab results available	~7.8M	~29M
Radiology reports available	~ 2.4M	~8M
Radiology reports submission (# of hospitals)	29	34
Clinical documents available	~ 1.1M	~4M
Transcribed documents submission (# of hospitals)	26	46
Opt-outs	798	2,031
Queries (#)	3,135	14,613
Queries (past 30 days)	~887	~14,000
Query portal adoption (# of signed participation agreements)	146	249
Direct messaging (# of users)	4	124

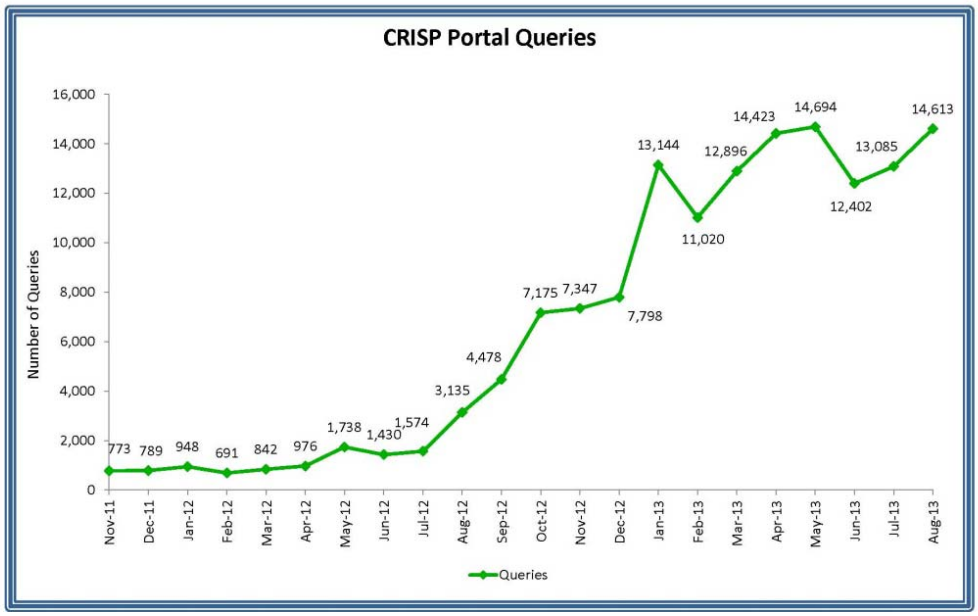
Query Services – Adoption

An HIE query service allows appropriately authorized and authenticated providers to find information on a patient from other providers and is often used for unplanned care. The CRISP query portal is a web-based system that contains patient health information from Maryland hospitals and other providers connected to the State-Designated HIE. Information available through the query portal includes patient demographics, laboratory results, radiology reports, discharge summaries, operative and consult notes, and medication fill history.



Queries Services – Volume

The State-Designated HIE has reported substantial growth of its query services since July 2012. CRISP moved its core infrastructure away from Optum's solution to the Mirth platform in the summer of 2013, which accounts for the variation in volume reported over the last several months.

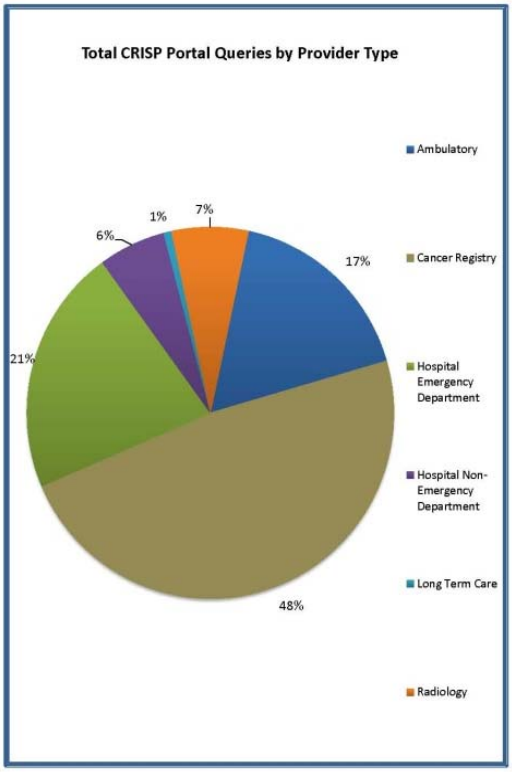


Query Services – Provider Distribution

Hospital cancer registry and emergency department staff account for nearly 69 percent of the query volume. In comparison, ambulatory practice use of query services is at about 17 percent. The use of query services by hospital non-emergency department staff and radiology are nearly the same at close to seven percent.

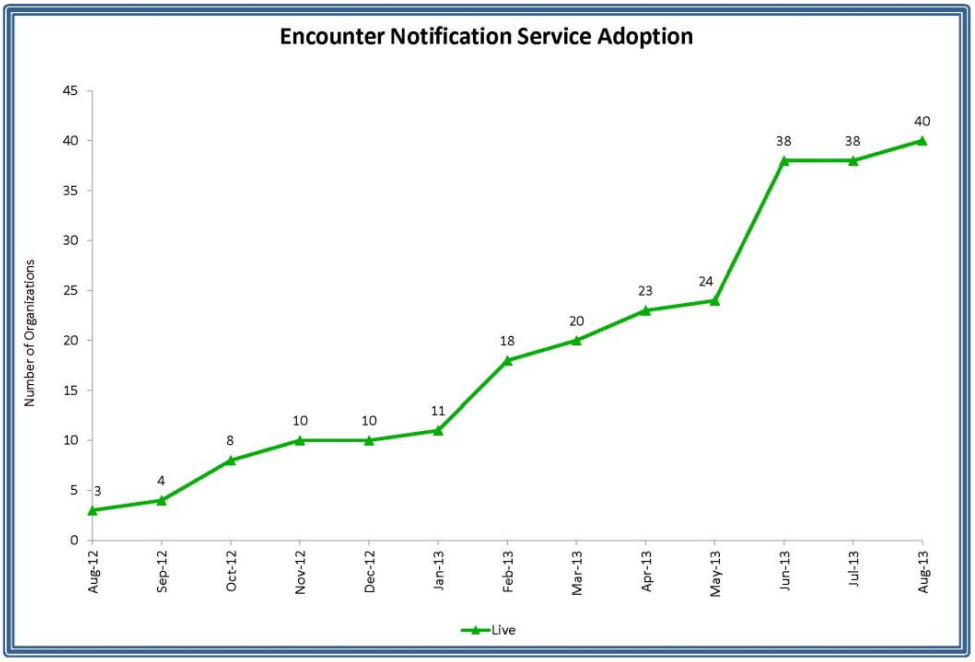
CRISP Portal Queries by Provider Type

Month		Provider Type: Ambulatory	Cancer Registry	Hospital Emergency Department	Hospital Non-Emergency Department	Long Term Care	Radiology	Total
Jun-12	#	331	475	315	38	181	88	1,430
	%	23	33	22	3	13	6	100
Jul-12	#	527	459	382	49	9	149	1,574
	%	33	29	24	3	1	9	100
Aug-12	#	1,027	715	781	96	17	499	3,135
	%	33	23	25	3	1	16	100
Sep-12	#	1,024	2,110	992	0	17	334	4,478
	%	23	47	22	0	0	7	100
Oct-12	#	1,449	3,890	1,193	176	19	448	7,175
	%	20	54	17	2	0	6	100
Nov-12	#	1,930	3,218	1,465	189	14	531	7,347
	%	26	44	20	3	0	7	100
Dec-12	#	1,955	2,948	1,516	233	53	1,093	7,798
	%	25	38	19	3	1	14	100
Jan-13	#	2,066	6,982	1,955	455	40	1,646	13,144
	%	16	53	15	3	0	13	100
Feb-13	#	1,414	6,176	1,987	596	61	786	11,020
	%	13	56	18	5	1	7	100
Mar-13	#	1,956	6,122	3,103	891	31	793	12,896
	%	15	47	24	7	0	6	100
Apr-13	#	2,137	7,017	3,370	1,056	60	783	14,423
	%	15	49	23	7	0	5	100
May-13	#	1,606	7,922	3,507	979	105	575	14,694
	%	11	54	24	7	1	4	100
Jun-13	#	1,831	5,630	3,256	1,023	65	597	12,402
	%	15	45	26	8	1	5	100
Jul-13	#	2,323	6,003	3,027	1,180	19	533	13,085
	%	18	46	23	9	0	4	100
Aug-13	#	2,065	7,623	2,858	1,376	118	573	14,613
	%	14	52	20	9	1	4	100
Total	#	24,345	68,226	30,419	8,404	979	9,555	141,928
Monthly Average	#	1,432	4,013	1,789	494	58	562	8,349



Encounter Notification Services – Participating Organizations

Encounter Notification Service (ENS) is a system that notifies providers when one of their patients has an encounter at a Maryland hospital, which includes patient admission, discharge, and transfer activity. Approximately 40 organizations have signed up for the ENS program with nearly 25 of them being primary care practices that participate in the Maryland Multi-Payer Patient Center Medical Home Program.



Report on Results of Uncompensated Care Policy and Final Recommendation to Suspend the Formula for Calculating the Hospital Specific Results

Health Services Cost Review Commission
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December 4, 2013

This document contains the Results of Uncompensated Care Policy and Final Recommendation to suspend the Charity Care Formula for Calculating the Hospital Specific Result. The recommendation, which is the same as the draft recommendation of November 6, 2013, is due for Commission action at the December 4, 2013 Public Commission Meeting. This recommendation was unamiously approved by the Commission.

Introduction

The purpose of this report is to detail the results of applying the Uncompensated Care Policy for Fiscal Year 2013 and to recommend that the Commission suspend the formula applied to arrive at hospital specific amounts of withdrawals from the Uncompensated Care Pool, based on inconsistencies in reporting of charity care expense across hospitals.

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 patients who cannot pay for care. The uncompensated care methodology has undergone substantial changes over the years since it was initially established in 1983. The most recent version of the policy was adopted by the Commission on June 6, 2012.

Under the current policy, the statewide uncompensated care provision (now 6.86 percent) is placed in each hospital's rates. Each hospital remits funds or withdraws funds from an uncompensated care pool administered by HSCRC based on application of the formula contained in the UCC policy of the HSCRC. Hospitals with a result above 6.86 percent withdraw money from the funds to cover additional uncompensated care while hospitals with a result below 6.86 percent pay into the fund.

The hospital specific uncompensated care levels used to determine whether the hospital will receive money from the pool, or pay into the pool are based on a predicted amount of uncompensated care derived from a regression formula and blended with actual experience of the hospital. In reviewing the data for application of the policy, the HSCRC staff determined that there were inconsistencies in reporting among hospitals in the allocation of uncompensated care between charity care and bad debts that resulted in differences in hospital specific allowances for total uncompensated care. As a result, the HSCRC staff is recommending that the distinction between charity care and bad debts be eliminated from the application of the policy until improved consistency in reporting can be achieved. By making this adjustment, the HSCRC staff believes that the reliability of the results from applying the policy is improved.

The Uncompensated Care Model

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 non-Medicare emergency department charges; and
- The proportion of a hospital's total charges from outpatient Medicaid, self-pay, and charity visits.

The amount of uncompensated care allowed for each hospital relative to the overall statewide uncompensated care provision is determined as follows:

1. Compute a three-year moving average for uncompensated care for each hospital to be used for 50% of the UCC value.
2. Estimate the uncompensated care regression coefficients using the most recent three years of data (while adding "dummy" variables for each year to control for trending).
3. Generate a predicted value for the hospital's uncompensated care rate by applying regression coefficients to the last available year of data.
4. Compute a 50/50 blend of the predicted and three-year moving average as the hospital's preliminary UCC.
5. Adjust the preliminary UCC rates from step 4 to achieve revenue neutrality to the system by multiplying the percentage difference between state-wide UCC rate totaled from the preliminary UCC amounts and actual experience from the last year.

UCC Result for FY 2014 Rate Year

The total prospective amount built into rates across the industry is the percentage actually experienced in the previous year of available data. If, for example, uncompensated care were $1 billion in FY 2012, this model would establish rates that would deliver $1 billion in fiscal year 2014, provided volumes and rates remain the same. The policy result is used to determine how the $1 billion in this example will be distributed among the hospitals on a revenue neutral basis through payments to or distributions from the pool

Appendix I shows the data used in the regression. Appendix II provides policy results from the regression and revenue neutrality adjustment for FY 2014.

The Charity Care Adjustment

The Charity Care Adjustment was adopted by the Commission on October 14, 2009 to recognize the charity care provided by Maryland hospitals and reported to the Commission 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 through regulation to 200 percent of FPL), and other requirements relating to hospital debt collection.

As the collection and reporting of data to the Commission on charity care provided was challenging for hospitals, the Charity Care Adjustment was delayed, and became effective July 1, 2011 (rate year 2012).

The current Charity Care Adjustment is calculated as 20% of the difference between the "Expected Rate" of charity care and the actual charity care provided, both measured as the percent of Gross Patient Revenue. It is calculated as follows:

1. Calculate actual Charity Care and UCC as a percent of gross patient revenue for each hospital.
2. Calculate expected rate of charity care, which is defined as the level of charity care if hospital provided charity at the state-average. The hospital's actual UCC is multiplied by the state-wide actual charity care as a percent of gross patient revenue to calculate expected rate of charity. The difference between the expected rate and actual charity provided as Charity Care is then multiplied by .20, which provides additional revenue for hospitals that had higher than expected charity care levels in a given year versus amounts reported as bad debts.

Commission staff has analyzed trends over time of the hospital-specific charity care reported since the Charity Care Adjustment was put in place. In this intervening period, several hospitals have implemented presumptive charity care software while others continue to attempt to identify charity care through historic methods. Figure 1 below illustrates the change in percentages of charity care reported as a percent of total UCC. Staff notes that while the total amount of UCC provided from 2011 to 2012 have remained consistent, there is very wide hospital-level variation in charity care from one year to the next, with one hospital providing 16.48% less charity care and another providing 54.81% more charity care in 2012 compared to 2011. By contrast, the difference in the charity care provided from 2009 to 2010 ranged between 1.59% less charity care and 6.68% more charity care for 2010. In addition, one hospital reports that charity care they provided was 99% of their UCC for 2012, an increase of more than double from the prior year.

Staff has also calculated the final UCC adjustment for FY 2014 with and without the Charity Care Adjustment. Figure 2 below illustrates the statewide average UCC adjustment of 6.68% both with and without the charity care adjustment consistent with the policy's revenue neutrality. Staff notes there are some differences in adjustments for each hospital, with some hospitals receiving more and some less, without the Charity Care Adjustment. Since the Charity Care Adjustment is applied as a revenue neutral scaling after the UCC is calculated resulting in some hospitals receiving more than their full UCC adjustment and some receiving less, and since staff has lack of confidence that the charity data is accurately and consistently reported, staff is concerned about the Charity Care Adjustment fairness.

Figure 1. Variation in Hospital Reported Charity Care from FYE 2011 to FYE 2012

Analysis of Uncompensated Care
FY 2012 vs. FY 2011
Bad Debt vs Charity Care from Schedule RE

	FYE 2012								FYE 2011								2012 CC%-
	Gross Patient Revenue	Bad Debt	BD %	Charity Care	CC %	Total UCC	UCC %	CC/UCC	Gross Patient Revenue	Bad Debt	BD %	Charity Care	CC %	Total UCC	UCC %	CC/UCC	2011 CC%
MEM. EASTON	184,647.5	113.6	0.06%	9,481.5	5.13%	9,595.1	5.20%	98.82%	173,171.5	5,391.8	3.11%	4,238.3	2.45%	9,630.1	5.56%	44.01%	54.81%
DORCHESTER GEN.	59,359.9	77.8	0.13%	3,216.0	5.42%	3,293.8	5.55%	97.64%	56,094.1	1,879.4	3.35%	2,036.7	3.63%	3,916.1	6.98%	52.01%	45.63%
CALVERT MEMORIAL	135,740.5	965.1	0.71%	6,770.4	4.99%	7,735.5	5.70%	87.52%	129,181.7	3,265.5	2.53%	4,171.1	3.23%	7,436.6	5.76%	56.09%	31.43%
CHESTER RIVER	65,051.7	957.3	1.47%	5,252.7	8.07%	6,210.0	9.55%	84.58%	62,310.3	1,742.9	2.80%	4,315.5	6.93%	6,058.4	9.72%	71.23%	13.35%
UNIVERSITY OF MD.	1,179,258.0	15,019.3	1.27%	58,436.8	4.96%	73,456.1	6.23%	79.55%	1,113,137.0	45,806.4	4.12%	41,235.8	3.70%	87,042.2	7.82%	47.37%	32.18%
WESTERN MARYLAND	308,555.8	4,637.0	1.50%	14,447.4	4.68%	19,084.4	6.19%	75.70%	304,982.5	4,754.8	1.56%	12,314.3	4.04%	17,069.1	5.60%	72.14%	3.56%
MARYLAND GEN.	185,438.4	7,138.9	3.85%	15,216.9	8.21%	22,355.8	12.06%	68.07%	183,154.5	13,507.1	7.37%	8,173.0	4.46%	21,680.1	11.84%	37.70%	30.37%
ST. AGNES	401,564.2	9,019.2	2.25%	17,723.3	4.41%	26,742.5	6.66%	66.27%	376,582.9	11,396.3	3.03%	14,578.7	3.87%	25,975.0	6.90%	56.13%	10.15%
BALTIMORE/WASHINGTOI	381,065.3	11,543.8	3.03%	21,373.2	5.61%	32,917.0	8.64%	64.93%	353,767.5	21,447.1	6.06%	9,945.7	2.81%	31,392.8	8.87%	31.68%	33.25%
PRINCE GEORGES HOSP	255,903.8	14,745.8	5.76%	24,104.9	9.42%	38,850.7	15.18%	62.04%	263,104.3	15,019.9	5.71%	22,602.8	8.59%	37,622.7	14.30%	60.08%	1.97%
U OF MD CANCER CENTE	59,320.8	2,200.9	3.71%	2,941.0	4.96%	5,141.9	8.67%	57.20%	50,120.4	3,222.1	6.43%	1,855.0	3.70%	5,077.1	10.13%	36.54%	20.66%
GARRETT CO.	42,709.9	2,122.2	4.97%	2,717.9	6.36%	4,840.1	11.33%	56.15%	40,536.7	1,191.3	2.94%	2,617.5	6.46%	3,808.8	9.40%	68.72%	-12.57%
MONTGOMERY GEN.	165,915.0	4,856.7	2.93%	5,899.8	3.56%	10,756.5	6.48%	54.85%	156,795.1	3,204.4	2.04%	5,962.0	3.80%	9,166.4	5.85%	65.04%	-10.19%
MERITUS	295,465.2	10,976.3	3.71%	11,500.6	3.89%	22,476.9	7.61%	51.17%	275,699.7	11,632.4	4.22%	9,658.4	3.50%	21,290.8	7.72%	45.36%	5.80%
ST. MARY'S	151,897.0	4,728.0	3.11%	4,836.1	3.18%	9,564.1	6.30%	50.57%	134,162.9	3,833.9	2.86%	3,387.5	2.52%	7,221.4	5.38%	46.91%	3.66%
UNION MEM.	422,530.7	15,179.3	3.59%	14,850.9	3.51%	30,030.2	7.11%	49.45%	400,597.1	13,283.6	3.32%	11,798.9	2.95%	25,082.5	6.26%	47.04%	2.41%
JOHNS HOPKINS	1,851,351.5	34,631.7	1.87%	32,982.5	1.78%	67,614.2	3.65%	48.78%	1,772,066.3	38,011.4	2.15%	29,978.3	1.69%	67,989.7	3.84%	44.09%	4.69%
HOLY CROSS	453,731.6	22,306.8	4.92%	21,047.2	4.64%	43,354.0	9.55%	48.55%	437,749.3	19,990.5	4.57%	16,579.5	3.79%	36,570.0	8.35%	45.34%	3.21%
LAUREL REGIONAL	118,724.4	8,673.4	7.31%	7,918.1	6.67%	16,591.5	13.97%	47.72%	103,068.6	6,428.5	6.24%	6,458.5	6.27%	12,887.0	12.50%	50.12%	-2.39%
MCCREADY	17,710.4	815.0	4.60%	739.7	4.18%	1,554.7	8.78%	47.58%	18,235.9	1,687.5	9.25%	896.6	4.92%	2,584.1	14.17%	34.70%	12.88%
BAYVIEW	584,860.1	27,925.0	4.77%	25,058.1	4.28%	52,983.1	9.06%	47.29%	530,152.1	15,013.0	2.83%	21,020.6	3.97%	36,033.6	6.80%	58.34%	-11.04%
MERCY	459,265.7	18,170.1	3.96%	14,458.3	3.15%	32,628.4	7.10%	44.31%	420,066.7	20,170.7	4.80%	12,057.1	2.87%	32,227.8	7.67%	37.41%	6.90%
PENINSULA GEN.	414,765.5	15,904.4	3.83%	12,458.5	3.00%	28,362.9	6.84%	43.93%	406,379.6	16,690.6	4.11%	10,108.0	2.49%	26,798.6	6.59%	37.72%	6.21%
BON SECOURS	130,651.8	12,162.9	9.31%	9,495.6	7.27%	21,658.5	16.58%	43.84%	128,847.2	8,425.8	6.54%	11,360.3	8.82%	19,786.1	15.36%	57.42%	-13.57%
KERNANS	117,995.4	4,292.0	3.64%	3,165.0	2.68%	7,457.0	6.32%	42.44%	103,574.6	5,576.0	5.38%	1,730.0	1.67%	7,306.0	7.05%	23.68%	18.76%
HARBOR HOSP.	209,694.3	9,673.5	4.61%	7,084.2	3.38%	16,757.7	7.99%	42.27%	200,717.5	9,858.2	4.91%	7,036.3	3.51%	16,894.5	8.42%	41.65%	0.63%
FREDERICK MEM.	334,410.3	12,580.3	3.76%	8,155.4	2.44%	20,735.7	6.20%	39.33%	323,934.9	12,996.5	4.01%	7,810.6	2.41%	20,807.1	6.42%	37.54%	1.79%
GOOD SAMARITAN	311,855.4	11,226.5	3.60%	7,232.5	2.32%	18,459.0	5.92%	39.18%	304,134.3	10,761.4	3.54%	6,482.3	2.13%	17,243.7	5.67%	37.59%	1.59%
SINAI	676,602.7	21,383.6	3.16%	13,494.0	1.99%	34,877.6	5.15%	38.69%	636,490.9	19,665.9	3.09%	10,981.2	1.73%	30,647.1	4.82%	35.83%	2.86%
ATLANTIC GENERAL	95,474.2	3,733.2	3.91%	2,271.8	2.38%	6,005.0	6.29%	37.83%	88,149.0	4,639.3	5.26%	1,319.7	1.50%	5,959.0	6.76%	22.15%	15.69%
SHADY GROVE	348,706.2	14,507.5	4.16%	8,708.1	2.50%	23,215.6	6.66%	37.51%	358,655.5	12,053.3	3.36%	8,392.8	2.34%	20,446.1	5.70%	41.05%	-3.54%
G.B.M.C.	426,432.4	8,208.5	1.92%	4,878.5	1.14%	13,087.0	3.07%	37.28%	427,052.5	8,362.9	1.96%	4,801.8	1.12%	13,164.7	3.08%	36.47%	0.80%
FRANKLIN SQUARE	477,082.0	21,620.3	4.53%	12,654.2	2.65%	34,274.5	7.18%	36.92%	439,004.2	16,598.6	3.78%	10,808.6	2.46%	27,407.2	6.24%	39.44%	-2.52%
HOWARD CO. GEN.	275,201.9	11,108.1	4.04%	6,269.2	2.28%	17,377.3	6.31%	36.08%	255,470.4	10,218.8	4.00%	4,705.0	1.84%	14,923.8	5.84%	31.53%	4.55%
ST. JOSEPH'S	354,785.6	9,900.7	2.79%	5,390.7	1.52%	15,291.4	4.31%	35.25%	362,195.0	12,065.2	3.33%	4,310.9	1.19%	16,376.1	4.52%	26.32%	8.93%
SUBURBAN	272,892.4	7,965.4	2.92%	4,296.8	1.57%	12,262.2	4.49%	35.04%	253,166.9	8,552.7	3.38%	3,894.7	1.54%	12,447.4	4.92%	31.29%	3.75%
UPPER CHESAPEAKE	283,588.0	12,081.7	4.26%	4,777.1	1.68%	16,858.8	5.94%	28.34%	259,833.1	13,889.6	5.35%	3,981.5	1.53%	17,871.1	6.88%	22.28%	6.06%
ANNE ARUNDEL GEN.	523,717.0	17,762.1	3.39%	6,430.1	1.23%	24,192.2	4.62%	26.58%	461,358.8	15,049.3	3.26%	5,799.9	1.26%	20,849.2	4.52%	27.82%	-1.24%
FORT WASHINGTON	46,176.4	4,226.2	9.15%	1,497.1	3.24%	5,723.3	12.39%	26.16%	47,165.0	5,577.8	11.83%	687.5	1.46%	6,265.3	13.28%	10.97%	15.18%
HARFORD MEM.	104,451.4	9,109.3	8.72%	3,051.4	2.92%	12,160.7	11.64%	25.09%	100,465.5	9,234.0	9.19%	3,232.3	3.22%	12,466.3	12.41%	25.93%	-0.84%
CARROLL CO. GEN.	243,424.4	8,697.5	3.57%	2,902.4	1.19%	11,599.9	4.77%	25.02%	214,427.8	8,252.4	3.85%	3,011.9	1.40%	11,264.3	5.25%	26.74%	-1.72%
UNION OF CECIL	148,428.4	8,925.5	6.01%	2,762.7	1.86%	11,688.2	7.87%	23.64%	137,717.9	9,476.9	6.88%	2,407.1	1.75%	11,884.0	8.63%	20.25%	3.38%
SHOCK TRAUMA	181,819.2	28,114.6	15.46%	8,405.0	4.62%	36,519.6	20.09%	23.02%	180,648.8	33,889.9	18.76%	6,680.0	3.70%	40,569.9	22.46%	16.47%	6.55%
NORTHWEST	238,730.1	13,078.8	5.48%	3,134.9	1.31%	16,213.7	6.79%	19.33%	227,677.3	13,251.9	5.82%	3,692.3	1.62%	16,944.2	7.44%	21.79%	-2.46%
DOCTORS HOSP.	214,285.3	14,078.4	6.57%	2,913.5	1.36%	16,991.9	7.93%	17.15%	213,054.4	14,422.5	6.77%	2,128.7	1.00%	16,551.2	7.77%	12.86%	4.29%
WASHINGTON ADV.	260,716.1	28,768.7	11.03%	5,819.0	2.23%	34,587.7	13.27%	16.82%	270,695.9	20,486.8	7.57%	10,229.5	3.78%	30,716.3	11.35%	33.30%	-16.48%
SOUTHERN MD.	241,038.8	11,549.8	4.79%	2,178.5	0.90%	13,728.3	5.70%	15.87%	249,258.4	16,887.5	6.78%	1,440.4	0.58%	18,327.9	7.35%	7.86%	8.01%
CIVISTA	126,393.9	7,657.3	6.06%	1,346.3	1.07%	9,003.6	7.12%	14.95%	115,504.2	7,134.7	6.18%	1,762.6	1.53%	8,897.3	7.70%	19.81%	-4.86%
ACUTE REGULATED	**14,839,386.5**	**545,120.0**	**3.67%**	**471,745.8**	**3.18%**	**1,016,865.8**	**6.85%**	**46.39%**	**14,120,316.7**	**585,899.0**	**4.15%**	**384,677.7**	**2.72%**	**970,576.7**	**6.87%**	**39.63%**	**6.76%**

Figure 2. Summary Results of the UCC Policy With and Without Charity Care Adjustment

Hospid	Hospital Name	FY 2014 Policy Result without Charity Adjustment	FY 2014 Policy Result with Charity Adjustment
210001	Meritus Medical Center	7.46%	7.51%
210002	Univ. of Maryland Medical System	7.39%	7.79%
210003	Prince Georges Hospital	14.43%	14.88%
210004	Holy Cross Hospital of Silver Spring	8.10%	8.13%
210005	Frederick Memorial Hospital	5.82%	5.72%
210006	Harford Memorial Hospital	9.95%	9.44%
210007	St. Josephs Hospital	4.10%	4.00%
210008	Mercy Medical Center, Inc.	6.93%	6.89%
210009	Johns Hopkins Hospital	4.42%	4.43%
210010	Dorchester General Hospital	7.36%	7.92%
210011	St. Agnes Hospital	6.87%	7.13%
210012	Sinai Hospital	5.78%	5.69%
210013	Bon Secours Hospital	15.77%	15.66%
210015	Franklin Square Hospital	7.50%	7.36%
210016	Washington Adventist Hospital	9.94%	9.13%
210017	Garrett County Memorial Hospital	9.12%	9.32%
210018	Montgomery General Hospital	6.23%	6.33%
210019	Peninsula Regional Medical Center	6.05%	6.00%
210022	Suburban Hospital Association,Inc	4.27%	4.17%
210023	Anne Arundel General Hospital	4.25%	4.06%
210024	Union Memorial Hospital	5.81%	5.84%
210027	Braddock Hospital	5.26%	5.61%
210028	St. Marys Hospital	7.37%	7.41%
210029	Johns Hopkins Bayview Med. Center	7.75%	7.75%
210030	Chester River Hospital Center	8.03%	8.74%
210032	Union Hospital of Cecil County	8.79%	8.41%
210033	Carroll County General Hospital	5.14%	4.93%
210034	Harbor Hospital Center	9.07%	8.99%
210035	Civista Medical Center	8.14%	7.68%
210037	Memorial Hospital at Easton	5.42%	5.96%
210038	Maryland General Hospital	12.33%	12.83%
210039	Calvert Memorial Hospital	6.60%	7.06%
210040	Northwest Hospital Center, Inc.	7.25%	6.87%
210043	North Arundel General Hospital	7.70%	8.01%
210044	Greater Baltimore Medical Center	3.40%	3.34%
210045	McCready Foundation, Inc.	10.10%	10.11%
210048	Howard County General Hospital	6.70%	6.56%
210049	Upper Chesepeake Medical Center	5.86%	5.63%
210051	Doctors Community Hospital	7.75%	7.27%
210054	Southern Maryland Hospital	7.81%	7.45%
210055	Laurel Regional Hospital	11.25%	11.27%
210056	Good Samaritan Hospital	5.77%	5.68%
210057	Shady Grove Adventist Hospital	6.78%	6.65%
** 210058	James Lawrence Kernan Hospital	6.17%	6.17%
210060	Fort Washington Medical Center	13.69%	13.17%
210061	Atlantic General Hospital	6.59%	6.48%
	STATE-WIDE	6.68%	6.68%

***** James Lawrence Kernan Hospital was excluded in the Regression Analysis, Revenue Neutrality and Charity Care Adjustment Calculations***

Affordable Care Act Impact on UCC: Future Considerations

By January 1, 2014 there is likely to be an increase in the number of Medicaid enrollees and an increase in the number of Marylanders with insurance coverage obtained through the Exchange. These changes in access to insurance will lead to the changes in uncompensated care levels and the need for new models. The HSCRC will need to address these changes through analysis and policy development, which it plans to undertake after the beginning of 2014.

The HSCRC will invite the submission of White Papers and analyses by hospitals, payers, and other parties on the model that should be used for uncompensated care and the methods that should be employed to project bad debts after July 1, 2014. In particular, the HSCRC staff would like to examine the impact on uncompensated care levels that may be associated with individuals who do not qualify for Medicaid or Exchange policies, such as uninsured immigrants, as well as other factors that may contribute to changes in uncompensated care levels in particular communities.

Public Comments on the Draft Recommendation

During the comment period that ended November 20, 2013, staff did not receive any comment letters.

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

Based on the wide hospital-level variation in the percentage of charity care reported from 2011 to 2012, staff does not have confidence that the current Charity Care Adjustment policy accurately distinguishes charity care from bad debts. Staff also is not confident that charity care is accurately and consistently reported by hospitals, which may well relate to the implementation of presumptive charity care software by some hospitals and insufficient identification of patients meeting charity guidelines by others. Finally, the current UCC Policy, absent the Charity Care Adjustment, fully adjusts rates for all uncompensated care historically provided by hospitals. Therefore, staff recommends that the Commission suspend the Charity Care Adjustment for FY 2014 until an alternative Charity Care Adjustment methodology is developed and approved.

APPENDIX I

Fiscal Year 2012 Data Used in Regression for FY 2014

Hospid	Hospital Name	Inpatient Medicaid Charges ($)	Inpatient Non-Medicare Charges through	Inpatient Self-Pay and Charity Charges ($)	Outpatient Medicaid Charges ($)	Outpatient Self-Pay and Charity Charges ($)	Outpatient Non-Medicare ED Charges($)	UCC in Rates (July 1, 2011)	Gross Patient Revenue ($)	Uncompensated Care ($)
210001	Meritus Medical Center	20,012,255	40,740,684	9,758,953	16,656,372	9,808,953	35,785,228	6.80%	$295,465,200	$22,476,900
210002	Univ. of Maryland Medical S	191,325,621	242,660,007	37,824,526	93,894,112	15,385,779	61,193,510	7.23%	$1,179,258,000	$73,456,050
210003	Prince Georges Hospital	67,742,703	95,991,280	13,688,382	17,831,810	13,091,571	42,304,960	13.19%	$255,903,800	$38,850,690
210004	Holy Cross Hospital of Silve	62,272,525	75,491,294	17,519,814	14,733,133	23,051,774	40,739,097	6.82%	$453,731,600	$43,354,000
210005	Frederick Memorial Hospital	23,320,499	59,563,298	8,134,251	11,772,689	5,890,677	29,121,449	5.26%	$334,410,300	$20,735,620
210006	Harford Memorial Hospital	7,407,466	22,360,723	2,011,165	7,287,954	2,535,224	16,632,251	8.81%	$104,451,400	$12,160,690
210007	St. Josephs Hospital	14,304,091	38,596,137	7,398,760	7,539,518	4,715,007	23,010,036	3.18%	$354,785,600	$15,291,350
210008	Mercy Medical Center, Inc.	58,349,429	38,939,173	4,693,904	33,997,163	9,747,210	32,944,866	6.57%	$459,265,700	$32,628,440
210009	Johns Hopkins Hospital	260,457,461	243,692,086	11,500,752	92,386,036	20,425,595	62,330,134	4.86%	$1,851,351,500	$67,614,200
210010	Dorchester General Hospital	3,667,761	7,927,307	2,618,545	6,399,721	2,287,383	8,390,358	6.25%	$59,359,900	$3,293,850
210011	St. Agnes Hospital	41,049,064	68,478,191	15,860,780	22,715,267	11,982,348	35,640,110	6.43%	$401,564,200	$26,742,410
210012	Sinai Hospital	90,194,264	98,902,269	7,005,087	44,375,731	13,552,199	44,478,315	5.96%	$676,602,700	$34,877,590
210013	Bon Secours Hospital	29,335,858	39,791,387	12,396,730	15,829,475	8,213,944	21,340,199	17.09%	$130,651,800	$21,658,510
210015	Franklin Square Hospital	55,621,600	77,734,048	8,651,313	43,192,909	12,363,488	59,710,842	6.13%	$477,082,000	$34,274,460
210016	Washington Adventist Hos	37,703,679	60,522,210	18,140,787	11,449,716	9,381,957	23,481,170	7.81%	$260,716,100	$34,587,720
210017	Garrett County Memorial Ho	2,923,118	4,315,249	1,185,684	4,251,960	1,696,382	6,118,047	6.68%	$42,709,900	$4,840,080
210018	Montgomery General Hospit	7,618,769	26,475,777	5,680,410	5,868,523	2,977,080	19,921,445	5.83%	$165,915,000	$10,756,470
210019	Peninsula Regional Medical	32,454,896	61,747,828	14,646,150	20,056,580	7,876,083	28,013,043	5.18%	$414,765,500	$28,362,900
210022	Suburban Hospital Associat	7,244,720	50,172,165	8,897,818	2,027,552	2,799,353	19,939,428	4.37%	$272,892,400	$12,262,210
210023	Anne Arundel General Hosp	28,829,463	65,376,099	9,695,511	12,580,832	6,431,486	33,414,589	3.74%	$523,717,000	$24,192,210
210024	Union Memorial Hospital	39,732,116	55,382,223	8,697,354	22,951,011	10,427,242	24,716,133	4.95%	$422,530,700	$30,030,200
210027	Braddock Hospital	20,631,993	37,790,308	6,799,490	17,500,280	5,993,824	19,587,902	3.58%	$308,555,800	$19,084,400
210028	St. Marys Hospital	8,914,352	19,097,838	3,493,102	11,627,715	3,855,575	27,120,627	6.31%	$151,897,000	$9,564,090
210029	Johns Hopkins Bayview Me	81,805,766	90,636,960	12,585,160	58,942,999	15,997,076	36,569,311	7.49%	$584,860,100	$52,983,100
210030	Chester River Hospital Cent	3,269,850	6,180,041	1,158,231	5,783,612	1,708,025	7,367,286	7.10%	$65,051,700	$6,210,020
210032	Union Hospital of Cecil Cou	13,902,670	18,996,344	3,703,339	18,506,675	4,094,721	19,531,894	6.81%	$148,428,400	$11,688,200
210033	Carroll County General Hosp	16,616,147	34,824,775	305,019	10,917,494	2,822,496	25,980,195	4.51%	$243,424,400	$11,599,910
210034	Harbor Hospital Center	38,081,255	38,476,964	5,059,322	21,678,150	5,880,409	25,913,761	7.30%	$209,694,300	$16,757,740
210035	Civista Medical Center	7,083,583	22,277,661	3,080,330	8,014,884	4,353,535	25,515,138	6.24%	$126,393,900	$9,003,600
210037	Memorial Hospital at Easton	12,979,388	21,080,375	3,040,740	11,910,647	4,244,372	16,247,143	4.52%	$184,647,500	$9,595,080
210038	Maryland General Hospital	50,765,479	43,882,643	6,277,572	26,822,417	6,718,433	22,659,964	11.04%	$185,438,390	$22,355,850
210039	Calvert Memorial Hospital	9,061,639	21,378,835	3,182,085	7,778,933	2,890,584	19,648,828	5.60%	$135,740,500	$7,735,570
210040	Northwest Hospital Center,	24,298,754	47,055,226	597,156	11,762,106	9,763,501	24,282,163	6.63%	$238,730,100	$16,213,700
210043	North Arundel General Hosp	25,697,173	65,578,457	9,645,831	21,443,224	9,204,031	47,511,557	6.67%	$381,065,300	$32,917,050
210044	Greater Baltimore Medical C	15,834,679	45,254,390	3,865,915	11,268,595	4,221,822	33,933,776	3.28%	$426,432,400	$13,087,000
210045	McCready Foundation, Inc.	445,897	66,801	206,793	2,164,044	1,153,382	3,033,071	8.22%	$17,710,400	$1,554,750
210048	Howard County General Hos	23,264,254	47,246,009	2,692,690	11,905,461	6,081,570	41,342,002	5.65%	$275,201,900	$17,377,260
210049	Upper Chesepeake Medical	12,672,059	41,110,129	1,487,982	10,497,392	3,261,163	33,385,725	5.62%	$283,588,000	$16,858,790
210051	Doctors Community Hospita	20,572,899	54,827,032	5,147,306	10,080,272	5,673,460	23,994,210	7.70%	$214,285,300	$16,991,840
210054	Southern Maryland Hospital	24,446,291	50,162,886	11,728,958	12,842,478	5,786,199	32,817,586	7.00%	$241,038,800	$13,728,300
210055	Laurel Regional Hospital	15,289,284	19,742,936	3,777,208	7,343,412	4,918,194	19,128,044	10.01%	$118,724,400	$16,591,420
210056	Good Samaritan Hospital	25,096,587	44,064,719	6,326,626	17,637,341	6,666,189	24,327,944	4.90%	$311,855,400	$18,459,090
210057	Shady Grove Adventist Hos	32,230,904	66,108,641	13,076,664	17,994,241	8,053,853	39,177,608	6.27%	$348,706,200	$23,215,600
** 210058	James Lawrence Kernan Hos	8,564,108	0	4,515,847	14,358,047	1,645,836	0	6.56%	$117,995,400	$7,457,000
210060	Fort Washington Medical C	1,725,996	7,233,526	1,260,761	5,828,084	2,502,568	16,325,202	10.56%	$46,176,440	$5,723,260
210061	Atlantic General Hospital	1,802,676	8,553,094	1,621,715	5,848,808	3,094,855	14,876,864	5.31%	$95,474,200	$6,005,000
	STATE-WIDE	1,568,056,933	2,326,486,025	336,126,671	853,897,328	323,580,572	1,269,503,011	6.12%	$14,480,251,130	$967,747,170

***** James Lawrence Kernan Hospital was excluded in the Regression Analysis, Revenue Neutrality and Charity Care Adjustment Calculations***

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APPENDIX II

Policy Results from the Regression and Revenue Neutrality Adjustment for FY 2014

Hospid	Hospital Name	UCC in Rates (July 1, 2011)	Actual UCC for FY '12	Predicted UCC	FY '10- FY '12 UCC AVERAGE	50/ 50 BLENDED UCC AVERAGE	Revenue Neutrality Adjustment	Policy Results without Charity Care Adjustemnt	Dollar Amount ($)
210001	Meritus Medical Center	6.80%	7.61%	7.24%	7.86%	7.55%	0.9879	7.46%	22,027,068
210002	Univ. of Maryland Medical Syste	7.23%	6.23%	7.58%	7.37%	7.48%	0.9879	7.39%	87,093,528
210003	Prince Georges Hospital	13.19%	15.18%	14.42%	14.79%	14.61%	0.9879	14.43%	36,920,920
210004	Holy Cross Hospital of Silver Spri	6.82%	9.55%	7.80%	8.61%	8.20%	0.9879	8.10%	36,769,363
210005	Frederick Memorial Hospital	5.26%	6.20%	5.66%	6.12%	5.89%	0.9879	5.82%	19,446,673
210006	Harford Memorial Hospital	8.81%	11.64%	8.61%	11.55%	10.08%	0.9879	9.95%	10,396,644
210007	St. Josephs Hospital	3.18%	4.31%	3.66%	4.64%	4.15%	0.9879	4.10%	14,547,641
210008	Mercy Medical Center, Inc.	6.57%	7.10%	6.40%	7.63%	7.01%	0.9879	6.93%	31,824,180
210009	Johns Hopkins Hospital	4.86%	3.65%	5.10%	3.85%	4.48%	0.9879	4.42%	81,842,556
210010	Dorchester General Hospital	6.25%	5.55%	9.09%	5.82%	7.46%	0.9879	7.36%	4,371,656
210011	St. Agnes Hospital	6.43%	6.66%	7.25%	6.66%	6.96%	0.9879	6.87%	27,598,009
210012	Sinai Hospital	5.96%	5.15%	6.52%	5.18%	5.85%	0.9879	5.78%	39,085,590
210013	Bon Secours Hospital	17.09%	16.58%	15.37%	16.57%	15.97%	0.9879	15.77%	20,607,091
210015	Franklin Square Hospital	6.13%	7.18%	8.70%	6.49%	7.60%	0.9879	7.50%	35,802,822
210016	Washington Adventist Hospital	7.81%	13.27%	8.81%	11.31%	10.06%	0.9879	9.94%	25,910,282
210017	Garrett County Memorial Hospital	6.68%	11.33%	8.61%	9.85%	9.23%	0.9879	9.12%	3,895,717
210018	Montgomery General Hospital	5.83%	6.48%	6.17%	6.45%	6.31%	0.9879	6.23%	10,339,915
210019	Peninsula Regional Medical Cente	5.18%	6.84%	5.64%	6.61%	6.12%	0.9879	6.05%	25,088,208
210022	Suburban Hospital Association,In	4.37%	4.49%	3.92%	4.74%	4.33%	0.9879	4.27%	11,665,454
210023	Anne Arundel General Hospital	3.74%	4.62%	3.99%	4.62%	4.30%	0.9879	4.25%	22,259,474
210024	Union Memorial Hospital	4.95%	7.11%	5.57%	6.18%	5.88%	0.9879	5.81%	24,529,451
210027	Braddock Hospital	3.58%	6.19%	5.13%	5.52%	5.32%	0.9879	5.26%	16,221,282
210028	St. Marys Hospital	6.31%	6.30%	8.60%	6.33%	7.46%	0.9879	7.37%	11,194,649
210029	Johns Hopkins Bayview Med. Ce	7.49%	9.06%	7.75%	7.93%	7.84%	0.9879	7.75%	45,310,232
210030	Chester River Hospital Center	7.10%	9.55%	6.75%	9.51%	8.13%	0.9879	8.03%	5,224,792
210032	Union Hospital of Cecil County	6.81%	7.87%	9.16%	8.63%	8.89%	0.9879	8.79%	13,041,256
210033	Carroll County General Hospital	4.51%	4.77%	5.60%	4.81%	5.20%	0.9879	5.14%	12,512,674
210034	Harbor Hospital Center	7.30%	7.99%	10.39%	7.97%	9.18%	0.9879	9.07%	19,010,303
210035	Civista Medical Center	6.24%	7.12%	9.40%	7.09%	8.24%	0.9879	8.14%	10,293,885
210037	Memorial Hospital at Easton	4.52%	5.20%	5.93%	5.05%	5.49%	0.9879	5.42%	10,016,156
210038	Maryland General Hospital	11.04%	12.06%	13.60%	11.37%	12.48%	0.9879	12.33%	22,863,438
210039	Calvert Memorial Hospital	5.60%	5.70%	7.54%	5.81%	6.68%	0.9879	6.60%	8,953,933
210040	Northwest Hospital Center, Inc.	6.63%	6.79%	7.17%	7.52%	7.34%	0.9879	7.25%	17,312,524
210043	North Arundel General Hospital	6.67%	8.64%	7.19%	8.40%	7.80%	0.9879	7.70%	29,353,691
210044	Greater Baltimore Medical Center	3.28%	3.07%	3.80%	3.09%	3.45%	0.9879	3.40%	14,513,911
210045	McCready Foundation, Inc.	8.22%	8.78%	8.76%	11.70%	10.23%	0.9879	10.10%	1,789,624
210048	Howard County General Hospital	5.65%	6.31%	7.55%	6.01%	6.78%	0.9879	6.70%	18,434,315
210049	Upper Chesepeake Medical Cente	5.62%	5.94%	5.37%	6.49%	5.93%	0.9879	5.86%	16,614,495
210051	Doctors Community Hospital	7.70%	7.93%	7.70%	7.99%	7.84%	0.9879	7.75%	16,606,262
210054	Southern Maryland Hospital	7.00%	5.70%	8.67%	7.14%	7.90%	0.9879	7.81%	18,822,553
210055	Laurel Regional Hospital	10.01%	13.97%	9.83%	12.95%	11.39%	0.9879	11.25%	13,360,081
210056	Good Samaritan Hospital	4.90%	5.92%	5.87%	5.81%	5.84%	0.9879	5.77%	18,001,136
210057	Shady Grove Adventist Hospital	6.27%	6.66%	7.51%	6.22%	6.87%	0.9879	6.78%	23,654,909
** 210058	James Lawrence Kernan Hospital	6.56%	6.32%	5.33%	7.01%	6.17%	1.0000	6.17%	7,276,232
210060	Fort Washington Medical Center	10.56%	12.39%	14.79%	12.93%	13.86%	0.9879	13.69%	6,323,195
210061	Atlantic General Hospital	5.31%	6.29%	6.78%	6.57%	6.68%	0.9879	6.59%	6,295,634
	STATE-WIDE	6.12%	6.68%	6.87%	6.66%	6.77%	0.9879	6.68%	975,023,402

***** James Lawrence Kernan Hospital was excluded in the Regression Analysis, Revenue Neutrality and Charity Care Adjustment Calculations***

Draft Recommendation for Updating the Quality Based Reimbursement and Maryland Hospital Acquired Conditions Programs for FY 2016

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

December 4, 2013

This document contains the preliminary staff recommendations for updating the Quality Based Reimbursement (QBR) and Maryland Hospital Acquired Conditions Programs for FY 2016 for consideration at the December 4, 2013 Public Commission Meeting. No action is required. Public comments should be sent to Dianne Feeney at the above address or by e-mail at Dianne.Feeney@Maryland.gov. For full consideration, comments must be received by December 20, 2013.

Draft Recommendation for Updating the Quality Based Reimbursement (QBR) and Maryland Hospital Acquired Condition (MHAC) Programs

A. Introduction

The HSCRC quality-based scaling methodologies and magnitudes "at risk" are important policy tools for providing strong incentives for hospitals to improve their quality performance over time.

Current HSCRC policy calls for the revenue neutral scaling of hospitals in allocating rewards and penalties based on performance on the HCSRC's Quality-based Reimbursement ("QBR") and Maryland Hospital Acquired Conditions ("MHAC") initiatives. The term "scaling" refers to the differential allocation of a pre-determined portion of base regulated hospital revenue based on assessment of the relative quality of hospital performance. The rewards (positive scaled amounts) or penalties (negative scaled amounts) are then applied to each hospital's update factor for the rate year; scaling amounts applied for quality performance are applied on a "one-time" basis (and not considered permanent revenue).

The reward and penalty allocations for the quality programs are computed 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. For State FY 2015 rates, as approved by the Commission, the HSCRC will scale a maximum penalty of 0.5% of base approved hospital inpatient revenue for the QBR program (which was the same level as FYs 2010 through 2014), and 3% for the MHAC program (which includes 2% for performance and 1% for improvement); this is a total of 3.5% of hospital base revenue related to quality.

Staff recommends updating the scaling magnitudes and methodologies to translate scores into rate updates for the QBR and MHACs initiatives to be applied to FY 2016 rates for each hospital.

B. Background

1. Centers for Medicare & Medicaid Services (CMS) Value Based Purchasing (VBP) and Hospital Acquired Conditions (HAC) Programs

The Patient Protection and Affordable Care Act of 2010 requires CMS to fund the aggregate Hospital VBP incentive payments by reducing the base operating diagnosis-related group (DRG) payment amounts that determine the Medicare payment for each hospital inpatient discharge. The law set the reduction at one percent in FY 2013, rising to 2 percent by FY 2017.

For the federal FY 2015 (October 1 to September 30) Hospital VBP program, CMS measures include four domains of hospital performance: clinical process of care; patient experience of care (HCAHPS survey measure); outcomes; and efficiency/Medicare spending per beneficiary. Results are weighted by CMS as listed below.

Figure 1. CMS VBP Domain Weights, FY 2015

	Clinical/Process	Patient Experience	Outcome	Efficiency/Medicare spending/beneficiary
FFY 2015	20%	30%	30%	20%

CMS has indicated its future emphasis will increasingly lean toward outcomes in the VBP program. Staff notes that for the CMS VBP program for FY 2015, CMS added additional outcome measures, including the Agency for Healthcare Research and Quality ("AHRQ") Patient Safety Indicator ("PSI") 90 Composite measure and the Centers for Disease Control National Health Safety Network ("CDC-NHSN") Central Line Associated Blood Stream Infection (CLABSI) measure.

The federal HAC program began in FFY 2012 when CMS disallowed an increase in DRG payment for cases with added complications in 14 narrowly defined categories. Beginning in FFY 2015, CMS established a second HAC program, which reduces payments of hospitals with scores in the top quartile for the performance period on their rate of Hospital Acquired Conditions as compared to the national average. In FY 2015, the maximum reduction is 1 percent for all DRGs. HSCRC staff also notes that CMS is using the PSI 90 Composite and the CDC CLABSI and Catheter-Associated Urinary Tract Infection ("CAUTI") measures for its HAC program, with PSI 90 and CLABSI also added to the VBP program, as noted above.

The CMS VBP and HAC measures for FY 2015 are listed in in Appendix I.

2. *QBR and MHAC Measures, Scaling and Magnitude at Risk to Date*

The QBR program uses the CMS/Joint Commission core process measures—e.g., aspirin upon arrival for the patient diagnosed with heart attack—, eight "patient experience of care" or Hospital Consumer Assessment of Healthcare Providers and Systems ("HCAHPS") measures, and a mortality domain newly adopted for rate year 2015 performance which includes all-cause inpatient mortality using the 3M Risk of Mortality classifications; the weighting for each domain is illustrated below.

Figure 2. Maryland QBR Domain Weights, FY 2015

	Clinical/Process	**Patient Experience**	**Outcome**
State FY 2015	40%	50%	10%

The QBR and MHAC Programs in Maryland together are consistent in design and intent with the CMS VBP program, and target performance on a robust set of process of care/effectiveness measures, patient safety measures, preventable complication rates, mortality rates, and patient experience of care measures. The programmatic elements of both the QBR and MHAC programs together comprise "VBP-like" measures that overlap the two programs.

The MHAC program currently uses a large subset of the 65 Potentially Preventable Complications developed by 3M Health Information Systems, which computes actual versus expected rates of complications adjusted for each patient by the All Patient Refined Diagnosis Related Group ("APR DRG"), and severity of illness ("SOI") category. The attainment scale measures the proportion of each hospital's inpatient revenue from excess PPCs compared to the benchmarks. For FY 15, the Commission approved targeting improvement in the following measures for scaling 1% of inpatient revenue, bringing the "at risk" revenue to 3% for the MHAC program. The 5 measures targeted under the improvement methodology are:

- PPC5 – Pneumonia and Other Lung Infections
- PPC6 – Aspiration Pneumonia
- PPC16 – Venous Thrombosis
- PPC24 – Renal Failure without Dialysis
- PPC35 – Septicemia and Severe Infections

Each year, staff will re-evaluate the PPCs used for the improvement scale based on improvement rates, prevalence, cost, and policy considerations.

The overall risk adjusted hospital-acquired potentially preventable complication (PPC) rates have declined from the first quarter of state fiscal year 2011 to the present by 34.6%. For FY 2015, the expected performance benchmark is calculated using a value of 15% below the statewide average performance for each PPC used in the MHAC program, as approved by the Commission last year.

Appendix II lists the measures used for the QBR and MHAC programs for FY 2015.

3. Value Based Purchasing Exemption Provisions

Pursuant to 1886(o)(1)(C)(iv) of the Social Security Act, "the Secretary may exempt such hospitals from the application of this subsection if the State which is paid under such section submits an annual report to the Secretary describing how a similar program in the State for a participating hospital or hospitals achieves or surpasses the measured results in terms of patient health outcomes and cost savings established under this subsection." VBP exemptions have been requested and granted for FYs 2013 and 2014. A VBP exemption request for FY 2015, which includes a report of Maryland's health outcomes and cost savings for the MHAC and QBR programs and a support letter from Secretary Sharfstein, was submitted to HHS Secretary Sebelius on November 15, 2013.

C. Assessment

Since the inception of the program and as is currently the case, HSCRC solicits input from stakeholder groups comprising the industry and payers to determine appropriate direction in areas of needed updates to the programs, including the measures used, and the programs' methodology components.

Staff examined measures proposed for the CMS VBP and HAC programs and those in the potential pool for the QBR program and in the MHAC program for 2015 and 2016 and notes that Maryland lags behind in adopting measures.

Staff has convened two work group meetings within the past month and has deliberated the addition of both the AHRQ PSI 90 measure and of the CMS CLABSI measure to the QBR program for FY 2016, again, both of which were already added to the CMS VBP program as of FY 2015. Staff believes there was broad agreement in the most recent work group meeting convened to add these measures for FY 2016, as well as to weight the measure domains as illustrated below, particularly in light of lacking an efficiency domain, and the need to continue

to focus on HCAHPS and to further focus on outcomes. Figure 3 details the CMS VBP domain weights compared with the Maryland domain weights for FY 2016.

Figure 3. CMS VBP and Maryland QBR Domain Weights, FY 2016

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

In addition to the added measures, the group agreed to align the list of process of care measures, threshold and benchmark values, and time lag periods with those used by CMS.[1] This will allow HSCRC to use the data submitted directly to CMS and to align our performance scores precisely, which to date have been slightly different from CMS'. Because CMS has a 9 month lag in the performance period in the data they release and because they use four rolling quarters to update hospitals' performance scores, the group agreed to move the performance period back by one quarter for FY 2015 and use October 1, 2012 to September 30, 2013, and use this same performance period going forward. This results in counting CY 2012 quarter 4 for performance in both FY 2014 and FY 2015. HSCRC agreed to re-calculate QBR scores using the performance period of CY 2013 when the data becomes available and to make any mid-year adjustments that are needed as a result of double counting FY 2012 quarter 4.

Appendix III details the baseline and performance periods for both the QBR and MHAC programs for 2014 through 2017.

To determine the potential impact of increasing the amount of revenue at risk for the QBR program, and in order to have an "at risk" magnitude consistent with the CMS VBP program, staff conducted modeling using the most recent results for FY 2014 to consider altering the magnitude of scaling to 1% of total inpatient revenue. The results in Appendix IV reveal that a total of $8,430,202 is redistributed under the revenue neutral scaling methodology. There was broad agreement at the last work group meeting to increase the revenue "at risk" to 1% for FY 2016.

For the MHAC program, modifying the benchmark for the FY 2016 to one that constitutes a more linear relationship between performance and scaling, as well as making minimal adjustments to the measures used and adding measures to the "improvement" PPC list, are issues to be discussed with the work group meeting to be convened on December 13, 2013. Considerations for increasing the number of "improvement" PPCs include deliberating those PPCs listed for monitoring in the new All-payer model demonstration application to CMMI, as well as those PPCs that overlap with the new CMS HAC program Domain 1, specifically those that comprise the AHRQ PPC 90 Composite measure.

In order to enhance our ability to meet the targets proposed in the CMMI All-payer model demonstration application, the Commission will be conducting a series of work groups to discuss pertinent issues and potential changes to current Commission policy. A Performance

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

Measurement and Improvement Work Group will be convened in early 2014 to consider issues relating to the Commission quality initiatives such as redesigning the incentives and shifting from revenue neutral scaling to establishing targets that allow hospitals to earn up to the full designated amounts if they meet the targets. While it is likely that any changes would apply to FY 17 payment policy, it is possible that the recommendations in this report for FY 16 could be altered after taking into account the timing and implications of the data available for the base and performance periods for payment adjustment. The work group will also be developing readmission and efficiency policies and a timeline and process for implementation under the new model. The readmission policy will be effective by July 1, and the efficiency standard at a future designated date.

D. Recommendations

For QBR and MHAC scaling, staff provides the following draft recommendations:

1. Allocate 1% of hospital approved inpatient revenue for QBR relative performance in FY 2016; and,
2. Increase the benchmark to establish the expected MHAC values to an amount greater than 15% better than the statewide average, which represents a more linear relationship between scaling and performance.

Appendix I. CMS VBP and HAC Measures for FY 2015

Process of Care Measures
AMI–7a ..... Fibrinolytic Therapy Received Within 30 Min- utes of Hospital Arrival.
AMI–8a ..... Primary PCI Received Within 90 Minutes of Hospital Arrival.
PN–3b ..... Blood Cultures Performed in the Emergency Department Prior to Initial Antibiotic Re- ceived in Hospital.
PN–6 ..... Initial Antibiotic Selection for CAP inImmunocompetent Patient.
SCIP–Card–2 .... Surgery Patients on Beta-Blocker Therapy Prior to Arrival Who Received a Beta- Blocker During the Perioperative Period.
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.
SCIP–Inf–9 ..... Urinary Catheter Removed on Postoperative Day 1 or Postoperative Day 2.
SCIP–VTE–2……. Surgery Patients Who Received Appropriate Venous Thromboembolism Prophylaxes Within 24 Hours Prior to Surgery to 24 Hours After Surgery.
MORT–30–AMI, MORT–30–HF , MORT–30–PN
PSI–90
CDC NHSN- CLABSI

HCAHPS Survey Dimension
Communication with Nurses .....
Communication with Doctors .....
Responsiveness of Hospital Staff .....
Pain Management .....
Communication about Medicines .....
Hospital Cleanliness & Quietness .....
Discharge Information .....
Overall Rating of Hospital .....

HAC MEASURES Implemented Since FY 2012

HAC 01: Foreign Object Retained After Surgery
HAC 02: Air Embolism
HAC 03: Blood Incompatibility
HAC 04: Stage III & Stage IV Pressure Ulcers
HAC 05: Falls and Trauma
HAC 06: Catheter-Associated Urinary Tract Infection
HAC 07: Vascular Catheter-Associated Infection
HAC 08: Surgical Site Infection - Mediastinitis After Coronary Artery Bypas Graft (CABG)
HAC 09: Manifestations of Poor Glycemic Control
HAC 10: Deep Vein Thrombosis/Pulmonary Embolism with Total Knee Replacement or Hip Replacement
HAC 11: Surgical Site Infection – Bariatric Surgery
HAC 12: Surgical Site Infection – Certain Orthopedic Procedure of Spine, Shoulder, and Elbow
HAC 13: Surgical Site Infection Following Cardiac Device Procedures
HAC 14: Iatrogenic Pneumothorax w/Venous Catheterization

HAC Measures Implemented FY 2015

- Domain 1- the Agency for Health Care Research and Quality (AHRQ) composite PSI #90 which includes the following indicators:
  - Pressure ulcer rate (PSI 3);
  - Iatrogenic pneumothorax rate (PSI 6);
  - Central venous catheter-related blood stream infection rate (PSI 7);
  - Postoperative hip fracture rate (PSI 8);
  - Postoperative pulmonary embolism (PE) or deep vein thrombosis rate (DVT) (PSI 12);
  - Postoperative sepsis rate (PSI 13);
  - Wound dehiscence rate (PSI 14); and
  - Accidental puncture and laceration rate (PSI 15).
- Domain 2- two healthcare-associated infection measures developed by the Centers for Disease Control and Prevention's (CDC) National Health Safety Network:
  - Central Line-Associated Blood Stream Infection and
  - Catheter-Associated Urinary Tract Infection.

Appendix II: QBR and MHAC Measures, FY 2015

QBR Measures

DOMAIN	MEASURE
AMI	AMI-8a - Primary PCI Received Within 90 Minutes of Hospital Arrival
CAC	CAC-3-Home Management Plan of Care (HMPC) Document Given to Patient/Caregiver
HF	HF-1 Discharge instructions
IMM	IMM-1a Pneumococcal vaccination
IMM	IMM-2 Influenza vaccination
PN	PN-3b Blood culture before first antibiotic – Pneumonia
PN	PN-6 Initial Antibiotic Selection for CAP in Immunocompetent Patient
SCIP	SCIP INF 1- Antibiotic given within 1 hour prior to surgical incision
SCIP	SCIP INF 4- Cardiac Surgery Patients with Controlled 6 A.M. Postoperative Serum Glucose
SCIP	SCIP INF 9- Urinary catheter removed on Postoperative Day 1 or Postoperative Day 2

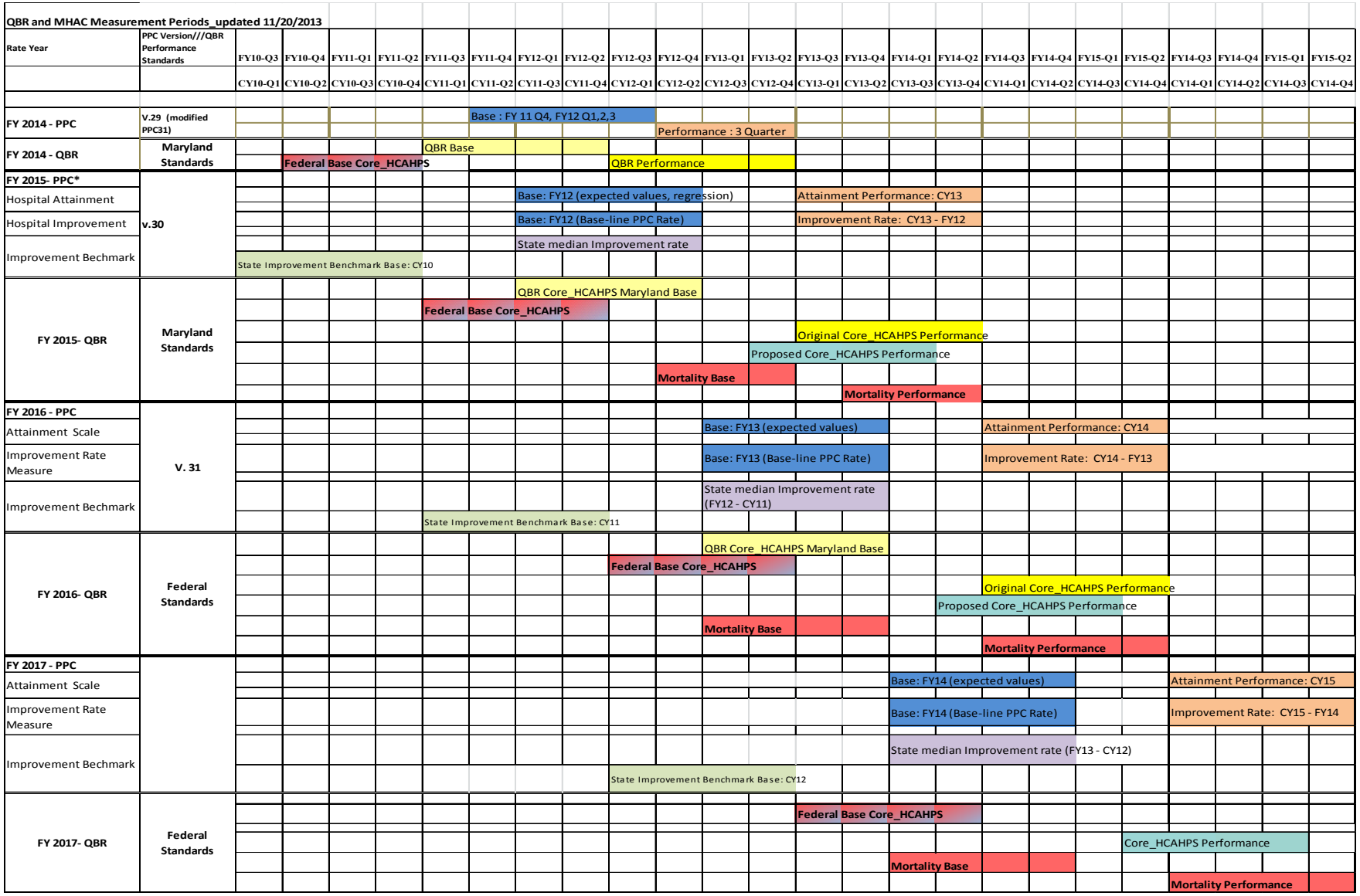
Domain	MEASURE
HCAHPS	Cleanliness and Quiteness of Hospital Envir
HCAHPS	Communication About Medicines (Q16-Q17)
HCAHPS	Communication With Doctors (Q5-Q7)
HCAHPS	Communication With Nurses (Q1-Q3)
HCAHPS	Discharge Information (Q19-Q20)
HCAHPS	Overall Rating of this Hospital
HCAHPS	Pain Management (Q13-Q14)
HCAHPS	Responsiveness of Hospital Staff (Q4,Q11)

Domain	Measure
MORTALITY	**3M Risk of Mortality**

	MHAC Measures	Rate Year 2015 (Based on FY2012 Q1234 Data)			
PPC #	PPC Description	Adm $	Adm T	Cases	Notes
			T Value<1.96		Exclusion Reason
1	Stroke & Intracranial Hemorrhage	$13,527.00	34.48	825	
2	Extreme CNS Complications	$14,228.00	25.38	415	
3	Acute Pulmonary Edema and Respiratory Failure without Ventilation	$9,808.00	57.56	4635	
4	Acute Pulmonary Edema and Respiratory Failure with Ventilation	$32,783.00	80.64	780	
5	Pneumonia & Other Lung Infections	$20,888.00	102.53	3174	
6	Aspiration Pneumonia	$16,628.00	55.74	1423	
7	Pulmonary Embolism	$15,051.00	32.59	583	
8	Other Pulmonary Complications	$9,405.00	49.36	3659	
9	Shock	$19,321.00	65.17	1506	
10	Congestive Heart Failure	$6,375.00	19.93	1235	
11	Acute Myocardial Infarction	$8,294.00	23.2	985	
12	Cardiac Arrythmias & Conduction Disturbances	$2,586.00	6.22	977	
13	Other Cardiac Complications	$5,664.00	7.34	207	
14	Ventricular Fibrillation/Cardiac Arrest	$20,204.00	47.42	706	
15	Peripheral Vascular Complications Except Venous Thrombosis	$16,972.00	21.58	202	
16	Venous Thrombosis	$17,730.00	50.87	1047	
17	Major Gastrointestinal Complications without Transfusion or Significant Bleeding	$15,508.00	35.18	639	
18	Major Gastrointestinal Complications with Transfusion or Significant Bleeding	$20,802.00	29.6	250	
19	Major Liver Complications	$21,822.00	35.52	333	
20	Other Gastrointestinal Complications without Transfusion or Significant Bleeding	$14,443.00	25.43	388	
21	Clostridium Difficile Colitis	$17,412.00	60.61	1524	Clinical
22	Urinary Tract Infection	$0.00	.	0	
23	GU Complications Except UTI	$7,016.00	12.72	407	
24	Renal Failure without Dialysis	$8,248.00	59.86	6925	
25	Renal Failure with Dialysis	$41,311.00	49.57	179	
26	Diabetic Ketoacidosis & Coma	$8,617.00	5.22	45	
27	Post-Hemorrhagic & Other Acute Anemia with Transfusion	$6,618.00	19.35	1070	
28	In-Hospital Trauma and Fractures	$8,560.00	8.9	134	
29	Poisonings Except from Anesthesia	$-1,331	-1.31	119	t-value
30	Poisonings due to Anesthesia	$14,971.00	1.34	1	t-value+case
31	Decubitus Ulcer	$32,815.00	49.94	288	
32	Transfusion Incompatibility Reaction	$21,835.00	1.97	1	t-value+case
33	Cellulitis	$10,216.00	26.15	831	
34	Moderate Infectious	$22,835.00	50.37	621	
35	Septicemia & Severe Infections	$18,853.00	68.29	1823	
36	Acute Mental Health Changes	$3,787.00	8.76	659	
37	Post-Operative Infection & Deep Wound Disruption Without Procedure	$16,777.00	46.81	1052	
38	Post-Operative Wound Infection & Deep Wound Disruption with Procedure	$34,433.00	29.67	93	
39	Reopening Surgical Site	$16,986.00	19.38	163	
40	Post-Operative Hemorrhage & Hematoma without Hemorrhage Control Procedure or I&D	$9,819.00	41.69	2283	
41	Post-Operative Hemorrhage & Hematoma with Hemorrhage Control Procedure or I&D Pr	$13,367.00	15.73	171	
42	Accidental Puncture/Laceration During Invasive Procedure	$6,503.00	19.09	1087	
43	Accidental Cut or Hemorrhage During Other Medical Care	$259.00	0.17	54	t-value
44	Other Surgical Complication - Mod	$14,852.00	22.46	284	
45	Post-procedure Foreign Bodies	$1,762.00	0.8	27	t-value
46	Post-Operative Substance Reaction & Non-O.R. Procedure for Foreign Body	$-8,577	-1.05	2	t-value+case
47	Encephalopathy	$11,772.00	36.2	1194	
48	Other Complications of Medical Care	$18,559.00	42	640	
49	Iatrogenic Pneumothrax	$9,534.00	23.58	782	
50	Mechanical Complication of Device, Implant & Graft	$16,993.00	34	495	
51	Gastrointestinal Ostomy Complications	$26,871.00	40.61	284	
52	Inflammation & Other Complications of Devices, Implants or Grafts Except Vascular Infec	$11,290.00	30.89	954	
53	Infection, Inflammation & Clotting Complications of Peripheral Vascular Catheters & Infus	$14,455.00	20.57	250	
54	Infections due to Central Venous Catheters	$29,152.00	45.6	315	
55	Obstetrical Hemorrhage without Transfusion	$406.00	1.39	1494	Clinical
56	Obstetrical Hemorrhage wtih Transfusion	$3,723.00	8.09	605	
57	Obstetric Lacerations & Other Trauma Without Instrumentation	$436.00	1.33	1160	t-value
58	Obstetric Lacerations & Other Trauma With Instrumentation	$609.00	1.11	409	t-value
59	Medical & Anesthesia Obstetric Complications	$1,239.00	2.8	646	
60	Major Puerperal Infection and Other Major Obstetric Complications	$-625	-0.58	107	t-value
61	Other Complications of Obstetrical Surgical & Perineal Wounds	$1,276.00	1.54	181	t-value
62	Delivery with Placental Complications	$688.00	1.03	281	t-value
63	Post-Operative Respiratory Failure with Tracheostomy	$103,152.00	62.65	46	Clinical
64	Other In-Hospital Adverse Events	$5,354.00	10.89	509	Clinical
65	Urinary Tract Infection without Catheter	$14,313.00	77.79	3794	
66	Catheter-Related Urinary Tract Infection	$11,718.00	10.18	93	

Note: Yellow and Gray Shaded PPCs are excluded. Green shaded PPCs are also used for the improvement measurement.

Appendix III. MHAC and QBR Base and Performance Periods, FY 2014-2017



Appendix IV

QBR Continuous Linear Scaling of Maximum Penalty of 0.50% vs. 1.00% of Hospital Inpatient CPC Revenue with Revenue Neutrality Adjustment - For Rate Year FY 2014

HOSPID	HOSPITAL NAME	GROSS INPATIENT CPC/CPE REVENUE	QBR FINAL SCORE	SCALING BASIS 0N 0.50%	SCALING BASIS 0N 1.00%	REVENUE IMPACT OF SCALING 0.50%	REVENUE IMPACT OF SCALING 1.00%	REVENUE NEUTRAL ADJUSTED REVENUE IMPACT OF SCALING 0.50%	REVENUE NEUTRAL ADJUSTED REVENUE IMPACT OF SCALING 1.00%	REVENUE NEUTRAL ADJUSTED GROSS REVENUE 0.50%	REVENUE NEUTRAL ADJUSTED GROSS REVENUE 1.00%	REVENUE NEUTRAL ADJUSTED PERCENT 0.50%	REVENUE NEUTRAL ADJUSTED PERCENT 1.00%
A	B	C	D	E	F	G	H	I	J	K	L	M	N
210003	Prince Georges Hospital Center	$163,205,248	0.2972	-0.500%	-1.000%	-$816,026	-$1,632,052	-$816,026	-$1,632,052	$162,389,221	$161,573,195	-0.500%	-1.000%
210043	Baltimore Washington Medical Center	$184,662,660	0.4688	-0.216%	-0.433%	-$399,417	-$798,834	-$399,417	-$798,834	$184,263,243	$183,863,826	-0.216%	-0.433%
210012	Sinai Hospital	$362,977,920	0.4811	-0.196%	-0.392%	-$711,291	-$1,422,583	-$711,291	-$1,422,583	$362,266,629	$361,555,337	-0.196%	-0.392%
210051	Doctors Community Hospital	$119,486,136	0.4867	-0.187%	-0.373%	-$223,082	-$446,165	-$223,082	-$446,165	$119,263,054	$119,039,971	-0.187%	-0.373%
210062	Southern Maryland Hospital Center	$145,134,232	0.4923	-0.177%	-0.355%	-$257,531	-$515,061	-$257,531	-$515,061	$144,876,701	$144,619,171	-0.177%	-0.355%
210061	Atlantic General Hospital	$33,780,340	0.4938	-0.175%	-0.350%	-$59,103	-$118,206	-$59,103	-$118,206	$33,721,237	$33,662,134	-0.175%	-0.350%
210022	Suburban Hospital	$151,177,296	0.5002	-0.164%	-0.329%	-$248,508	-$497,017	-$248,508	-$497,017	$150,928,788	$150,680,279	-0.164%	-0.329%
210015	Franklin Square Hospital Center	$241,738,193	0.5108	-0.147%	-0.294%	-$355,010	-$710,020	-$355,010	-$710,020	$241,383,183	$241,028,173	-0.147%	-0.294%
210055	Laurel Regional Hospital	$53,359,459	0.514	-0.142%	-0.283%	-$75,539	-$151,078	-$75,539	-$151,078	$53,283,920	$53,208,381	-0.142%	-0.283%
210040	Northwest Hospital Center	$121,348,486	0.5191	-0.133%	-0.266%	-$161,557	-$323,114	-$161,557	-$323,114	$121,186,929	$121,025,372	-0.133%	-0.266%
210024	Union Memorial Hospital	$215,726,275	0.5248	-0.124%	-0.247%	-$266,878	-$533,755	-$266,878	-$533,755	$215,459,397	$215,192,520	-0.124%	-0.247%
210013	Bon Secours Hospital	$70,685,898	0.5345	-0.108%	-0.215%	-$76,111	-$152,221	-$76,111	-$152,221	$70,609,787	$70,533,677	-0.108%	-0.215%
210035	Civista Medical Center	$60,770,370	0.5438	-0.092%	-0.185%	-$56,090	-$112,180	-$56,090	-$112,180	$60,714,280	$60,658,190	-0.092%	-0.185%
210056	Good Samaritan Hospital	$172,932,011	0.5485	-0.085%	-0.169%	-$146,176	-$292,353	-$146,176	-$292,353	$172,785,835	$172,639,658	-0.085%	-0.169%
210032	Union of Cecil	$60,653,880	0.551	-0.080%	-0.161%	-$48,763	-$97,525	-$48,763	-$97,525	$60,605,117	$60,556,355	-0.080%	-0.161%
210011	St. Agnes Hospital	$209,768,089	0.5535	-0.076%	-0.153%	-$159,973	-$319,946	-$159,973	-$319,946	$209,608,116	$209,448,143	-0.076%	-0.153%
210048	Howard County General Hospital	$146,791,098	0.5673	-0.053%	-0.107%	-$78,454	-$156,909	-$78,454	-$156,909	$146,712,644	$146,634,189	-0.053%	-0.107%
210039	Calvert Memorial Hospital	$57,493,422	0.5756	-0.040%	-0.079%	-$22,839	-$45,677	-$22,839	-$45,677	$57,470,583	$57,447,745	-0.040%	-0.079%
210034	Harbor Hospital Center	$116,221,680	0.5793	-0.034%	-0.067%	-$39,058	-$78,117	-$39,058	-$78,117	$116,182,622	$116,143,563	-0.034%	-0.067%
210029	Johns Hopkins Bayview Medical Center	$248,923,504	0.5963	-0.006%	-0.011%	-$13,693	-$27,386	-$13,693	-$27,386	$248,909,811	$248,896,118	-0.006%	-0.011%
210002	University of Maryland Hospital	$783,335,558	0.6008	0.002%	0.004%	$15,188	$30,376	$11,838	$23,675	$783,347,396	$783,359,233	0.002%	0.003%
210030	Chester River Hospital Center	$26,318,692	0.6017	0.003%	0.007%	$902	$1,804	$703	$1,406	$26,319,395	$26,320,098	0.003%	0.005%
210060	Fort Washington Medical Center	$16,249,592	0.6082	0.014%	0.028%	$2,303	$4,606	$1,795	$3,590	$16,251,387	$16,253,182	0.011%	0.022%
210005	Frederick Memorial Hospital	$170,650,516	0.609	0.015%	0.031%	$26,444	$52,887	$20,611	$41,221	$170,671,127	$170,691,737	0.012%	0.024%
210018	Montgomery General Hospital	$79,741,456	0.6187	0.032%	0.063%	$25,145	$50,289	$19,598	$39,196	$79,761,054	$79,780,652	0.025%	0.049%
210019	Peninsula Regional Medical Center	$219,461,838	0.6188	0.032%	0.063%	$69,565	$139,130	$54,220	$108,440	$219,516,058	$219,570,278	0.025%	0.049%
210027	Western MD Regional Medical Center	$159,433,379	0.6241	0.040%	0.081%	$64,508	$129,015	$50,278	$100,556	$159,483,657	$159,533,935	0.032%	0.063%
210023	Anne Arundel Medical Center	$250,956,754	0.6255	0.043%	0.086%	$107,347	$214,694	$83,668	$167,336	$251,040,422	$251,124,090	0.033%	0.067%
210001	Meritus Hospital	$165,746,592	0.6308	0.052%	0.103%	$85,422	$170,843	$66,579	$133,158	$165,813,171	$165,879,750	0.040%	0.080%
210017	Garrett County Memorial Hospital	$17,951,439	0.6345	0.058%	0.115%	$10,350	$20,700	$8,067	$16,134	$17,959,506	$17,967,573	0.045%	0.090%
210049	Upper Chesapeake Medical Center	$115,418,544	0.6438	0.073%	0.146%	$84,291	$168,581	$65,697	$131,394	$115,484,241	$115,549,938	0.057%	0.114%
210044	Greater Baltimore Medical Center	$184,989,402	0.6457	0.076%	0.152%	$140,909	$281,819	$109,827	$219,654	$185,099,229	$185,209,056	0.059%	0.119%
210007	St. Joseph Medical Center	$180,611,979	0.6463	0.077%	0.154%	$139,367	$278,733	$108,624	$217,249	$180,720,603	$180,829,228	0.060%	0.120%
210016	Washington Adventist Hospital	$155,015,406	0.6517	0.086%	0.172%	$133,455	$266,910	$104,017	$208,033	$155,119,423	$155,223,439	0.067%	0.134%
210004	Holy Cross Hospital	$276,326,064	0.6532	0.089%	0.177%	$244,745	$489,491	$190,758	$381,516	$276,516,822	$276,707,580	0.069%	0.138%
210057	Shady Grove Adventist Hospital	$195,270,023	0.666	0.110%	0.219%	$214,276	$428,553	$167,010	$334,020	$195,437,033	$195,604,043	0.086%	0.171%
210008	Mercy Medical Center	$191,948,526	0.687	0.144%	0.289%	$277,274	$554,549	$216,112	$432,223	$192,164,638	$192,380,749	0.113%	0.225%
210037	Memorial Hospital at Easton	$82,689,144	0.6998	0.166%	0.331%	$136,945	$273,891	$106,737	$213,474	$82,795,881	$82,902,618	0.129%	0.258%
210038	Maryland General Hospital	$105,819,110	0.7008	0.167%	0.335%	$177,001	$354,003	$137,957	$275,915	$105,957,067	$106,095,025	0.130%	0.261%
210033	Carroll Hospital Center	$118,189,180	0.7018	0.169%	0.338%	$199,647	$399,293	$155,607	$311,215	$118,344,787	$118,500,395	0.132%	0.263%
210006	Harford Memorial Hospital	$42,495,040	0.739	0.230%	0.461%	$97,919	$195,837	$76,319	$152,638	$42,571,359	$42,647,678	0.180%	0.359%
210010	Dorchester General Hospital	$28,755,684	0.7679	0.278%	0.556%	$79,999	$159,999	$62,353	$124,705	$28,818,037	$28,880,389	0.217%	0.434%
210009	Johns Hopkins Hospital	$843,010,098	0.8032	0.337%	0.673%	$2,837,275	$5,674,550	$2,211,412	$4,422,825	$845,221,510	$847,432,923	0.262%	0.525%
210028	St. Mary's Hospital	$53,846,970	0.8667	0.442%	0.883%	$237,761	$475,521	$185,314	$370,628	$54,032,284	$54,217,598	0.344%	0.688%
	Statewide Total	$7,401,067,183				$1,192,936	$2,385,872	$0	$0	$7,401,067,183	$7,401,067,183		
		Average Score:	59.96%	Total rewards		5,408,037	10,816,073	0.779414	0.779414				
				Total Penalties		-4,215,101	-8,430,202						

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

John M. Colmers
Chairman

Herbert S. Wong, Ph.D.
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Thomas R. Mullen

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Donna Kinzer
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Stephen Ports
Principal Deputy Director
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Gerard J. Schmith
Deputy Director
Hospital Rate Setting

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

TO: Commissioners

FROM: Legal Department

DATE: November 26, 2013

RE: Hearing and Meeting Schedule

Public Session:

January 8, 2014	1:00 p.m., 4160 Patterson Avenue, HSCRC Conference Room
February 5, 2014	1:00 p.m., 4160 Patterson Avenue, HSCRC Conference Room

Please note, Commissioner's packets will be available in the Commission's office at 11:45 p.m.

The Agenda for the Executive and Public Sessions will be available for your review on the Thursday before the Commission meeting on the Commission's website.
http://hscrc.maryland.gov/commissionMeetingSchedule2013.cfm

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