STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

John M. Colmers
Chairman

Herbert S. Wong, Ph.D.
Vice-Chairman

Joseph R. Antos, Ph.D.

George H. Bone, M.D.

Jack C. Keane

Bernadette C. Loftus, M.D.

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Stephen Ports
Principal Deputy Director
Policy and Operations

Gerard J. Schmith
Deputy Director
Hospital Rate Setting

Mary Beth Pohl
Deputy Director
Research and Methodology

485th MEETING OF THE HEALTH SERVICES COST REVIEW COMMISSION
February 1, 2012

EXECUTIVE SESSION
1:00 p.m.

1. **Waiver Issues**

PUBLIC SESSION OF THE HEALTH SERVICES COST REVIEW COMMISSION
1:30 p.m.

1. **Review of the Executive Session and Public Meeting Minutes of December 8, 2011 Meeting**

2. **Executive Director's Report + Memo on State Operating Budget**

3. **Docket Status – Cases Closed**

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

4. **Docket Status – Cases Open**

   2146A – Johns Hopkins Health System
   2147A – Johns Hopkins Health System
   2148N – Mount Washington Pediatric Hospital

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

6. **Final Recommendation regarding Medicaid's Request to Modify the Calculation of Current Financing Deposits**

7. **Draft Recommendation regarding Proposed Changes to NSPII Policies from the Maryland Higher Education Commission**

8. **Summary of HSCRC Response to a Joint Chairmen's Report (JCR) Request regarding Capital Replacement Costs**

9. **Hearing and Meeting Schedule**

Executive Session Minutes
Of the
Health Services Cost Review Commission

December 8, 2011

Upon motion made, Chairman Colmers called the meeting to order at 9:31 a.m.

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

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

Steve Ports, Jerry Schmith, and Dennis Phelps attended representing staff.

Also attending was Stan Lustman Commission Counsel.

Item One

The Chairman updated the Commissioners on the current stage in the process for hiring an Executive Director.

Item Two

The Chairman reported on the status of discussions with CMS on delivery system initiatives and modernization of the Medicare waiver.

The Executive Session was adjourned at 9:57 a.m.

MINUTES OF THE
484th MEETING OF THE
HEALTH SERVICES COST REVIEW COMMISSION

December 8, 2011

Chairman John Colmers called the meeting to order at 10:02 a.m. Commissioners George H. Bone, M.D., Jack C. Keane, Bernadette C. Loftus, M.D., Thomas R. Mullen, and Herbert S. Wong, Ph.D. were also present.

REPORT OF THE EXECUTIVE SESSION OF DECEMBER 8, 2011

Dennis Phelps, Associate Director-Audit & Compliance, summarized the minutes of the December 8, 2011 Executive Session.

ITEM I
EXECUTIVE AND PUBLIC SESSIONS OF NOVEMBER 2, 2011

The Commission voted unanimously to approve the minutes of the November 2, 2011 Executive Session and Public Sessions.

ITEM II
EXECUTIVE DIRECTOR'S REPORT

Steve Ports, Acting Executive Director, reported to the Commission of the progress on current and future projects. They included: 1) continuing to work with the 31 Admission-Readmission Revenue (ARR) hospitals to finalize their Interventions Plans, i.e., strategies to be implemented to facilitate a decrease in readmissions; 2) calculating ARR Charge-per Episode weights; 3) meeting with a Work Group on Capital Policy to respond to the Legislative Budget Committees' Joint Chairmen's Report request for a letter concerning the inclusion of capital replacement costs in hospital rates; 4) beginning discussions in the Work group on possible changes to the current capital policy in the context of bundled payment strategies designed to reduce hospital volumes; 5) reconvening the Community Benefit Work Group to review hospitals' experience with the FY 2011 reporting and discussing changes for the FY 2012 report; 6) establishing a Review Committee to evaluate the adequacy of the responses and scoring hospitals on the sufficiency of the Community Benefit Report's Narrative Report; making progress on completing the various components required to issue rate orders, e.g., calculation of uncompensated care provision, settling-up Charge-per-Case (CPC) and Charge-per-Visit (CPV) programs for FY2011, calculating FY 2012 CPC and CPV targets, and finalizing Total Patient Revenue hospital budgets.

Mr. Ports stated that we have not received a definitive answer from the Centers for Medicare and Medicaid Services (CMS) as to whether the HSCRC may participate as a convener in the CMS

Bundled Payments for Care Improvement Initiative. Mr. Ports reported that there will be a conference call with CMS on November 3rd to seek approval to participate in the initiative. Nevertheless, Mr. Ports recommended that hospitals that are interested in participating in any of the initiative models should apply separately to CMS.

Mr. Ports reported that as requested by the legislature, staff will convene a workgroup to discuss the HSCRC's current capital policy and to discuss whether changes should be made to at least some elements of the policy as a result of the new payment initiatives.

ITEM III
DOCKET STATUS CASES CLOSED

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

ITEM IV
DOCKET STATUS CASES OPEN

Johns Hopkins Health System – 2143A

On October 25, 2011, the Johns Hopkins Health System filed an application on behalf of Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center (the "Hospitals") requesting approval to participate in a new global rate arrangement with Olympus Managed Health for solid organ, bone marrow transplant, and cardiovascular services for a period of one year beginning November 1, 2011.

After review of the data utilized to calculate the case rates, staff recommended that: 1) the requirement that an application be filed 30 days prior to the proposed effective date of an alternative method of rate determination arrangement be waived; and 2) the Hospitals' request be approved for one year beginning November 1, 2011. In addition, staff recommended that the approval be based on the execution of the standard Memorandum of Understanding.

The Commission voted unanimously to approve staff's recommendation. Chairman Colmers recused himself from consideration of this application.

MedStar Health – 2144A

On November 2, 2011, MedStar Health filed an application for an Alternative Method of Rate

Determination on behalf of Union Memorial Hospital requesting approval for the continued participation in a global price arrangement for orthopedic services with the NFL Player Joint Replacement Benefit Plan for a period of one year beginning December 1, 2011.

Although there has been no activity under this arrangement since its original approval in 2007, staff still believes that the Hospital can achieve favorable performance under this arrangement. Therefore, staff recommended: 1) the requirement that an application be filed 30 days prior to the proposed effective date of an alternative method of rate determination arrangement be waived; and 2) the Hospital's request be approved for one year beginning December 1, 2011.

The Commission voted unanimously to approve staff's recommendation.

Johns Hopkins Health System – 2145A

On November 21, 2011, the Johns Hopkins Health System filed an application for an Alternative Method of Rate Determination on behalf of Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center (the "Hospitals") for a new global rate arrangement with PepsiCo Inc. for cardiovascular and orthopedic services for a period of one year beginning December 1, 2011.

After review of the data utilized to calculate the case rates, staff recommended that: 1) the requirement that an application be filed 30 days prior to the proposed effective date of an alternative method of rate determination arrangement be waived; and 2) the Hospitals' request be approved for one year beginning December 1, 2011. In addition, staff recommended that the approval be based on the execution of the standard Memorandum of Understanding.

The Commission voted unanimously to approve staff's recommendation. Chairman Colmers recused himself from consideration of this application.

ITEM V
RECOMMENDATION TO ADOPT REVISED LABOR AND DELIVERY RELATIVE VALUE UNITS

Chris O'Brien, Chief-Audit & Compliance, recommended that the Commission adopt the revised Labor and Delivery (L&D) relative value units (RVUs), developed by a sub-group of the Maryland Hospital Association's (MHA's) Financial Technical Issues Task Force. Mr. O'Brien stated that the revised RVUs were promulgated to all Maryland hospitals for review and comment, and that no comments were received.

Richard Pelligeno, Manager of Financial Planning and Contract Management-Calvert Memorial Hospital and Anne Hubbard, Assistant Vice President, Financial Advocacy of MHA, explained

the nature of the proposed changes to the L&D RVUs.

The Commission voted unanimously to approve staff's recommendation.

ITEM VI
DRAFT RECOMMENDATION REGARDING HOSPITAL GRADUATE MEDICAL EDUCATION REPORTING CHANGES

Mary Beth Pohl, Deputy Director-Research and Methodology, summarized the proposed changes in the reporting data associated with Graduate Medical Education (GME). The proposed changes to Direct Medical Education (DME) reporting included: 1) discontinuing the annual reporting schedules utilized to report the direct costs and Full-Time-Equivalents (FTEs) of ineligible Interns and Residents to reflect the policy change; and 2) modifying the instructions associated with the reporting of Eligible Interns and Residents (Schedule P4) to adopt the definition for calculating FTEs utilized by Medicare.

The proposed changes to the annual reporting of Intern and Resident FTEs for purposes of accounting for Indirect Medical Education costs included: 1) changing the reporting from a one-day snap shot of the number of Interns and Residents at each hospital to the time, in FTEs, that Interns and Residents provided patient care during the fiscal year; 2) modifying and clarifying the reporting requirements for the HSCRC's Intern and Resident Survey (Schedule IRS) to follow Medicare's Intern and Resident Reporting System (IRIS).

ITEM VII
LEGAL REPORT

Regulations

Proposed

Rate Application and Approval Procedures- COMAR 10.37.10.07-1

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

The Commission voted unanimously to approve the promulgation of this amended regulation.

TRIBUTE TO DR. HAROLD A. (HAL) COHEN

Chairman Colmers initiated the tribute by describing how almost 40 years ago Dr. Cohen laid the cornerstone of the HSCRC. Dr. Cohen built it up, and gave it life, meaning, and sustainability. He was the consummate leader. He was able to attract the very brightest and most dedicated public servants. The "Tree of Hal" extends far and wide; wherever you find expertise and innovation in the quest to improve our health system, you will find the footprints of Hal Cohen. We can attempt to follow in his footsteps, but we can never fill his shoes. Hal Cohen has dedicated his life to the tenets to the HSCRC, and we, his followers and admirers, feel forever blessed and grateful.

Commissioner Keane delivered the Commission's statement acknowledging, on behalf of all current and former Commissioners and staff, the contributions made by Dr. Cohen to the HSCRC's work on behalf of the citizens of Maryland. Mr. Keane noted that from the beginning Dr. Cohen focused on creating incentives that would encourage hospitals to provide efficient and effective care. He spearheaded the successful efforts to obtain the Medicare waiver that allowed the HSCRC to unify hospital payment methods and incentives across all payers. The waiver not only brought coherence and effectiveness to our payment methods, stability to our hospitals, and savings to our community, but also brought universal and equal access to hospital services regardless of financial means. In Maryland, no hospital needs to or is allowed to, turn away a patient because he or she cannot afford to pay for necessary care. Dr. Cohen provided not only this lofty vision but also a method for achieving it.

Dr. Cohen also led the way in recognizing that the promotion of high quality care is an integral component of the HSCRC's mission. Dr. Cohen believed that low quality is, by definition, inefficient and ineffective care. In the 1980s, Dr. Cohen set in motion a process that has lead to a series of efforts - including the MHA's quality measurement program, the HSCRC's quality-based scaling technique, and; readmission reduction program- that have given quality an explicit and quantifiable place in our regulatory strategy.

Commissioner Keane noted the Dr. Cohen embraced good ideas, regardless of their source, with alacrity and passion, even when those ideas required him to revise his own positions.

As Commissioner Keane noted, during his tenure as Executive Director and since then, as an ardent supporter, and occasional critic, Dr. Cohen has been a ceaseless advocate of the Commission's work. Dr. Cohen has made contributions that have helped the Commissioners and staff to become better people and more effective public servants. He never missed an opportunity to identify a mistake, to compliment an individual, to broker a compromise or suggest a worthwhile goal, or to share his vast fund of healthcare insights and knowledge. At all times, he has kept his eyes on the prize - - which is better, more affordable care for all - - and he never allowed ego, politics, convenience, or bureaucracy to deter him from that objective. All of us who have had the privilege of working with Hal have been richly rewarded in the most important currencies of life – inspiration, honesty, passion, and generosity. Our past and our future bear his indelible mark.

Chairman Colmers presented Dr. Cohen with a plaque from the Commissioners and staff of the HSCRC.

Steve Ports read citations from Governor O'Malley, the Maryland Senate and House of Delegates and from Senator Cardin honoring Dr. Cohen for his exemplary service to the citizens of Maryland.

The tributes continued with comments by Alvin Powers, the first Chairman of the Commission. Mr. Powers recalled that after the Commissioners were in place, recruiting began for an Executive Director. One of the original commissioners, Dr. Mancur Olsen, showed Mr. Powers the resume of Dr. Harold Cohen from the University of Georgia, and the rest is history. Hal, in turn, recruited Dr. Jack Cook, Dr. Graham Atkinson. And the State supplied two attorneys, Stan Lustman and Jay Levy. Hal said our team is in place. Thus was formed what became known as the Group of Five.

Hal was the quarterback ready to take on the powerful Maryland Hospital Association. Not only was Hal guiding the rate setting activities of the Commission, he was simultaneously educating the Commissioners. What started as an experiment has lasted 37 years.

Mr. Powers stated that Hal is a supreme problem solver because for his ability to take the most complex subject and reduce it to its simplest components, making it understandable not only to the public but also to the Commissioners.

Mr. Powers praised Hal as his friend and mentor, as well as an outstanding human being and a man of great dignity loved by all. Mr. Powers asserted that the State of Maryland owes Hal all the accolades in the world and that he was honored to be a part of this tribute.

Former Commissioner James Lowthers declared that as the longest serving Commissioner; he heard more testimony from Dr. Cohen than any Commissioner in the history of the HSCRC. Mr. Lowthers stated that on occasion he was forced to do a lot of work researching issues that Hal brought up in his testimony because he did not understand them. This was especially true when they disagreed on an issue. However, Mr. Lowthers observed that it was easy for him to like Hal because the vast majority of the time they were in agreement.

Mr. Lowthers stated that he could not miss the opportunity to honor Hal for his great work, but also to thank him for all that he taught him over his time as a Commissioner.

Former Executive Director Robert Murray stated that he could think of no better reason to come before the Commission for the first time since he was Executive Director than to have this opportunity to pay tribute to his friend, mentor, colleague, and his hero Hal Cohen. Mr. Murray observed that Dr. Cohen was his hero because: 1) he is a great mentor and teacher; 2) he set the standard for how to deal with hospital efficiency, incentives, and promoting social mission; and 3) he created this amazingly elegant, productive, and beneficial system for hospitals, and more importantly for the patients that they serve. While Dr. Cohen was open minded, cooperative, and had the willingness to lend his insight into any issue, Hal had the incredible sense of when

something wasn't quite right, and was quick to tell people that things didn't quite fit. Hal had no qualms about telling anyone, anywhere, anytime when something was just an outright bad idea.

Hal was heroic by having the courage to resist the status quo, politics, and special interests in order to do the right thing. Mr. Murray stated that in an age of increasing self-centeredness and self-interest, Hal's feats of courage and nobility of purpose are inspirational. It was all about helping others without the sense of benefiting ourselves. It is that heroism that Hal instilled in all of us, which is the glue that holds this system together, as much, if not more than the Medicare waiver, this idea and desire to do something bigger than ourselves.

Mr. Murray called on everyone here to thank and honor Hal by rekindling that sense of solidarity and keep improving this wonderful system that he created for our benefit and the benefit of everyone in the State.

Former Commission Counsel Jay Levy stated that if you know Hal, you know that he doesn't suffer fools gladly. However, he made an exception in the case of himself and Stan Lustman in order to accomplish what he wanted to do for the citizens of Maryland because he knew he had to teach us the rate setting system so that we could explain it to the Court of Appeals.

Mr. Levy praised Dr. Cohen for his courage in not yielding to political pressure when that pressure was severe. Mr. Levy stated that Hal was a wonderful mentor and one of the finest men that he has ever known and thanked him for all that he has done for him and for the citizens of Maryland.

Former Commissioner Samuel Lin, M.D., Ph.D., reported that he brought greetings and regards from former Commissioner Wilarda Edwards, M.D. Dr. Lin stated that we as Commissioners learned a lot watching Hal in action and we appreciate the influence that he had on us. Dr. Lin thanked Hal for all that he has done for the State of Maryland.

Dr. Cohen responded by stating that he was overwhelmed with the tribute and expressed his thanks for the opportunity to serve this wonderful body. He noted that he had a wonderful staff and was pleased to have worked with all of them, but what people may not understand is how much the HSCRC is a Commission driven operation.

Dr. Cohen noted that much of what we have done today is to look back. But Dr. Cohen noted that he has lived his life looking forward, so he wanted to speak about going forward. First, Dr. Cohen asserted that funding full financial requirements for efficient and effective hospitals in an equitable manner; was the key. According to Hal, we have a brilliant law that doesn't say much more than that.

One of the most important things about this Commission is its independence. The Commission must maintain its independence from every individual payer and from the hospitals and be the honest broker.

Dr. Cohen stated that the waiver is obviously extremely important; however, it was his opinion that the biggest threat to the waiver is that Medicaid is no longer paying its fair share. All of us, the Commission, the hospitals, and the payers must work to make this an all-payer system in our tradition.

Dr. Cohen observed that his experience with the Michigan Hospital Association has taught him that focused quality initiatives really make a difference. Consequently, Dr. Cohen asked the Commission to consider an all-out war on sepsis.

In addition, Dr. Cohen stated that he has always had a very strong affection for the nursing profession. The fact that his wife Jo was a nurse is the reason that he did his dissertation on health care. When there was a serious nursing shortage, he spearheaded the creation of Nurse Support Programs (NSP) I and II. Now there is another problem, a dire shortage of nurse managers. According to Dr. Cohen, there is great demand for nurse managers to provide primary care and to manage the care of patients in the community. Dr. Cohen asked that the Commission consider creating a Nurse Support Program III to train nurse managers.

In closing Dr. Cohen wished everyone a great future.

ITEM VII
HEARING AND MEETING SCHEDULE

January 11, 2012	Time to be determined, 4160 Patterson Avenue, HSCRC Conference Room
February 1, 2012	Time to be determined, 4160 Patterson Avenue, HSCRC Conference Room

There being no further business, the meeting was adjourned at 11:24 a.m.

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Executive Director's Report
February 1, 2012

Monitoring Maryland Performance

Monitoring Maryland Performance shows that the inpatient charge per case increased by 8.28% year-ending November 2011 versus year-ending November 2010 while cases (admissions plus newborns) decreased 3.62% for the same period. Outpatient revenue increased 11.86% over the same period.

Budget

See the Memorandum from Steve Ports.

Update Factor Process

A workgroup consisting of staff, hospital representatives, and payers met on January 25, 2012 to discuss the process for developing a recommendation for the FY2013 update factor. The staff reviewed the major factors to be considered in the process: waiver status, the State budget, the current run rate on Monitoring Maryland Performance, slippage, and one-day stay effects among others. The group discussed a truncated process that would allow consideration of the data while allowing input from all parties with a few workgroup meeting to provide common information to all parties. The staff expects to develop a draft recommendation for the April Commission meeting.

Medicare Waiver Test

The current waiver test compares the cumulative growth rate in Medicare expenditures per inpatient discharge for Maryland versus the U.S. The State passes the waiver test as long as Maryland's cumulative growth in the Medicare payments per case does not exceed the cumulative growth of payments per case nationally. The base year for this test is 1981, when Maryland's payment per case was $2,971.65 and the nation's was $2,293.09. In the last waiver letter (dated November 15, 2011), Maryland's cumulative growth stood at 320.23% while the nation stood at 360.38% with Maryland at $12,847.85 and the nation at $10,556.88 per

discharge. If the nation were to remain unchanged going forward, Maryland payments per discharge could rise by 9.55% before we failed this test. (We refer to this last measure as "the relative waiver test.")

While the most recent CMS waiver letter suggests that the State has some room under the test, the letter is based on data that lags current events. The November 2011 letter encompasses a data period year ending September 30, 2010. The waiver letters typically lag current events by 15 to 18 months. *Monitoring Maryland Performance* for year ending November 2011 shows that the Charge per Case is growing by 8.28%, far above the 4.3% budgeted under last year's update factor discussions (update factor plus the Medicaid assessment plus seed funding for ARR). This high run rate is contributing to an erosion of the waiver cushion. A number of factors may account for this growth such as continued shifts of short-stay cases to observation, TPR shifts of services, activities to reduce readmissions under the ARR policy, and charging patterns. The staff is currently analyzing each of these components to better understand the current trend.

ARR Implementation

Under the new ARR methodology, discharges are bundled into 30 day episodes of care, and the case weights under APR-DRGs are recalculated to reflect the new definition of an episode of care. The staff has now issued case mix weights under this policy. We have also sent to the case mix liaisons base year data with episode of care definitions for each discharge. The staff has also provided the SAS code for developing episodes and weights to provide transparency in the calculations. Next week, we will release operational policy guidelines for the program and in mid-February will hold discussions on reporting requirements under the policy.

Update on Rate Orders

Rate orders for all hospitals have been issued except for the Johns Hopkins Hospital, the University of Maryland Medical System, and Mercy Medical Center.

VBP exemption

CMS has granted the State an exemption for the QBR program but plans to continue to monitor the program. The HSCRC will be required to report annually on the status of QBR as a condition of a continued exemption from the Federal program, showing that the State's program meets or exceeds the Federal program in quality improvement and cost savings.

ARR exemption

In anticipation of Federal requirements for Medicare's treatment for readmissions, CMS asked the HSCRC to provide an explanation of current efforts around readmissions in Maryland. The staff provided a letter to CMS on January 31, 2012, describing both the ARR and TPR programs, explaining their goals, basic structures, and the incentives for reducing hospital readmissions within the State.

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Memorandum

To: HSCRC Commissioners

From: Steve Ports

Date: February 1, 2012

RE: Summary of FY 13 State Operating, HSCRC, and Medicaid Budgets

This memorandum is intended to describe the overall FY13 Maryland State Operating Budget picture, highlight the Medicaid provisions in the budget that relate to the Health Services Cost Review Commission, and update the Commission on any changes proposed in the HSCRC FY 13 budget.

State Budget

In December 2010, the Maryland General Assembly's Spending Affordability Committee recommended that the State eliminate the structural deficit over a 3-year period – in FY 2012, FY 2013, and FY 2014. At the time, the State's structural Deficit was estimated to be $2 billion. The FY 12 budget is expected to reduce the deficit to $1.1 billion by YE FY2012. With the cost containment measures and revenue enhancements proposed in the budget and related legislation, it is expected that by the end of FY 2013, the deficit would be reduced to $404 million.

Medicaid Budget

Overall, the proposed budget increases Medicaid expenditures by 3.37% (from $7.08 billion to $7.32 billion), and enrollment is expected to grow by 5.6%. Included in the budget is the continuation of provider taxes on all major Medicaid providers. The language included in the Budget Reconciliation Act last year (during the 2011 Legislative Session) requires that:

> *For fiscal year 2013 and every fiscal year thereafter, the Commission and the Department of Health and Mental Hygiene shall adopt policies that will provide at least $389,825,000 from a combination of special fund revenues and General Fund savings from reduced hospital or other payments made by the Medicaid program. The policies adopted under this subsection shall be in lieu of the hospital assessment and remittance revenue generated in fiscal year 2012, but may include hospital assessments and remittances. To the maximum extent*

possible, the Commission and the Department shall adopt policies that preserve the State's Medicare waiver.

The amounted included in the Medicaid budget from the Medicaid Deficit Assessment/Remittance in FY 13 is $413 million – a 6.2% increase from FY 2012, or an additional $24 million. As in FY 13, the Commission is to determine how this burden would be distributed among hospitals (through a remittance), and payers or purchasers of care (through an assessment). In FY 12, the Commission required that $333 million of the $389 million assessment/remittance be implemented through an increase in rates and the remaining $56 million accrue through a remittance from HSCRC regulated hospitals.

In addition, the Medicaid budget anticipates cost containment from the following policy changes:

- Tiering of Clinic and ED Services – The Medicaid budget assumes a savings of $30 million in General Funds, $60 million total funds (including the federal match). This assumes the Commission would change its existing policy of prohibiting hospitals to tier their Clinic and ED rates.

- DSH Pooling – Savings to Medicaid of $9.1 in General Funds and $18.2 in total funds (including the federal match) is expected from pooling Disproportionate Share similar to how uncompensated care is currently pooled. The FY 13 Budget Reconciliation and Financing Act includes language in the HSCRC's statute to authorize (but does not require) the Commission to conduct such DSH pooling.

- Reducing Payments for Enrollees in Medicaid's Medically Needy Program – The Budget expects $36 million in General Fund savings and $72 million total savings from this policy. Details have not been provided on how this would be implemented.

- MCO Rate Cut – MCO rates are proposed to be reduced by 1% in FY 13. In FY 12, MCO rates were cut by 1.5%.

- Freeze in payments to D.C. and non-HSCRC Hospitals

The growth in the Medicaid budget is based on three factors: enrollment, utilization and rates. The budget assumes that hospital rates would increase by 3.8% for inpatient services, and 4.65% for outpatient services, for a combined increase of 4.13%. This rate of increase includes the following elements:

- Market Basket;
- Inflation Forecast Error;
- HSCRC Policy Adjustment;
- Slippage;
- Volume Adjustment;
- Case Mix;
- Markup; and
- Medicaid Deficit Assessment

HSCRC Budget

There were not cuts to the requested HSCRC budget for FY 2013. The budget as proposed would increase over FY 12 by 3.7%. Since the Commission received 3 new positions in the FY 12 budget (for a total of 34), no new positions are included in the FY 13 budget.

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

AS OF JANUARY 23, 2012

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

Docket Number	Hospital Name	Date Docketed	Decision Required by:	Rate Order Must be Issued by:	Purpose	Analyst's Initials	File Status
2146A	The Johns Hopkins Health System	12/16/2011	N/A	N/A	ARM	DNP	OPEN
2147A	The Johns Hopkins Health System	12/19/2011	N/A	N/A	ARM	DNP	OPEN
2148N	Mount Washington Pediatric Hospital	1/3/2012	2/2/2012	6/1/2012	EKG	CK	OPEN

PROCEEDINGS REQUIRING COMMISSION ACTION - NOT ON OPEN DOCKET

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION	*	**COMMISSION**	
JOHNS HOPKINS HEALTH	*	**DOCKET:**	**2011**
SYSTEM	*	**FOLIO:**	**1956**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2146A**

Staff Recommendation

February 1, 2012

I. INTRODUCTION

On December 16, 2011, Johns Hopkins Health System ("System") filed a renewal application on behalf of its member hospitals, Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, and Howard County General Hospital (the "Hospitals") requesting approval from the HSCRC to continue participation in global rates for cardiovascular procedures with Global Excel Management, Inc. The Hospitals request that the Commission approve the arrangement for an additional year beginning December 30, 2011.

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 the actual experience under the arrangement for the last year has been favorable, and staff is satisfied that the Hospitals can continue to achieve favorable performance under this arrangement.

VI. STAFF RECOMMENDATION

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

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION	*	**COMMISSION**	
JOHNS HOPKINS HEALTH	*	**DOCKET:**	**2011**
SYSTEM	*	**FOLIO:**	**1957**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2147A**

Staff Recommendation

February 1, 2012

I. INTRODUCTION

Johns Hopkins Health System (the System) filed a renewal application with the HSCRC on December 16, 2011 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 (JHHC) as providers for TRICARE patients. The requested approval is for a period of one year beginning January 1, 2012.

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 all Maryland hospital services will be paid based on HSCRC rates.

III. STAFF FINDINGS

Staff found that the experience under this arrangement for FY 2011 was favorable.

IV. STAFF RECOMMENDATION

The staff recommends that the Commission: 1) waive the requirement that alternative applications be filed 30 days before the proposed effective date; 2) approve the Hospitals' application for participation in an alternative method of rate determination capitation arrangement for a one year period commencing January 1, 2012. 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.

IN RE: THE PARTIAL RATE	*	**BEFORE THE HEALTH SERVICES**
APPLICATION OF	*	**COST REVIEW COMMISSION**
MOUNT WASHINGTON	*	**DOCKET: 2012**
PEDIATRIC HOSPITAL	*	**FOLIO: 1958**
BALTIMORE, MARYLAND	*	**PROCEEDING: 2148N**

Staff Recommendation

February 1, 2012

Introduction

On January 3, 2012, Mount Washington Pediatric Hospital (the "Hospital"), a member of the University of Maryland Medical System, submitted a partial rate application to the Commission requesting a rate for Electrocardiography (EKG) services. The Hospital is requesting the lower of a per RVU rate based on its costs and volumes, or a per RVU rate based on the statewide median for this service adjusted by the FY 2012 Update Factor. The effective date for this service is January 1, 2012.

Staff Evaluation

To determine if the Hospital's EKG 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 EKG services for FY 2012. Based on information received, it was determined that the EKG rate based on the Hospital's projected data would be $3.03 per RVU, while the statewide median rate for EKG services is $2.89 per RVU as adjusted for the FY 2012 Update Factor of 1.56%.

Recommendation

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

1. That COMAR 10.37.10.07 requiring that rate applications be filed 60 days before the opening of a new service be waived;
2. That an EKG rate of $2.89 per RVU be approved effective February 1, 2012;
3. That the EKG rate not be rate realigned until a full year's cost experience data have been reported to the Commission.

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

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

February 1, 2012

This final recommendation was approved at the February 1, 2012 Commission Meeting.

Purpose

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

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

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

Background

Since its inception, Maryland's all payer system has accounted for the social costs associated with the training of physicians by building costs for DME and IME into hospital rates. The Commission makes adjustments for DME and IME in its methodologies in order to assess the adequacy of hospital rates relative to peer institutions through the reasonableness of charges (ROC) and the inter-hospital cost comparison (ICC) methodologies.

To account for DME and IME in the ROC and ICC, the Commission requires hospitals to submit annual financial and resident count reports. Hospitals report DME on Schedules P4A to P4I of the Annual Report of Revenue, Expenses, and Volume (Annual Report). For DME, the HSCRC quantifies the dollar amount associated with training program components, including salaries/compensation and fringe benefits. Hospitals report the resident count on the HSCRC's Intern and Resident Survey (Schedule IRS). HSCRC staff utilizes the resident count in quantifying the added cost to patient charges attributable to training (i.e., inefficiencies resulting from use of less experienced physicians for the provision of medical care). The HSCRC captures IME costs through a regression analysis.

While computing the ROC this summer, HSCRC staff identified an error in hospital reporting of resident counts in the previous year. Following the correction of the error, HSCRC staff opened a

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

discussion with the Payment Workgroup to review and potentially modify HSCRC's collection of GME data. New collection practices would aim to provide HSCRC with a more complete understanding of GME and allow for GME data review/auditing.

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

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

Unless specifically addressed, these recommendations do not change current GME policies in place, such as resident caps.

Recommended Updates to DME Reporting

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

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

Recommended Changes to IME Reporting

Background:

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

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

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

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

HSCRC staff found that CMS' Medicare IME reporting requirements are substantially in line with the intent of the HSCRC for hospital reporting of resident counts. This includes CMS'

Medicare regulations regarding the definition of an accredited residency program/inclusion of fellows for purposes of IME, the determination of countable time (e.g., research vs. clinical time), determination of hospital vs. out of hospital, and the definition of full time equivalency seemed overall to be in line with HSCRC policy. Note that Medicare regulations are far more instructive regarding which residents and which time is accounted for in IME.

The aspect of Medicare IME regulation that differs most from HSCRC reporting requirements is that Medicare does count for IME certain days that a resident spends outside of regulated space when performing patient care activities (e.g., rotations at affiliated physician practices). HSCRC staff has asked the GME workgroup to comment on the extent of resident rotations outside of the regulated space, which is countable under CMS' Medicare regulation §412.105(f)(1)(ii)(C). HSCRC staff received no comments from hospitals. HSCRC staff believes that following Medicare policy on this is acceptable.

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

Section added

Calculation of IME/ Weighting of FTEs:

When developing the count of FTEs for IME, HSCRC staff recommends a "straight" count of FTEs, with no added weighting polices. This approach is the most in line with the HSCRC's current methodologies for counting residents for IME.

Note that CMS' Medicare IME regulations indicate several different weighting multipliers. For example, Medicare assigns less weight to fellows by applying a 0.5 multiplier to each fellow's FTE. HSCRC staff does not recommend following Medicare IME regulations for IME FTE weighting.

Addition of a GME Review/Audit

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

Section added

Potential Impact of Recommended Changes

For DME, HSCRC staff anticipates administrative simplification from the consolidation of schedules P4 and P5. In past years, HSCRC staff has added the counts and dollars reported by hospitals on P4 and P5 to produce aggregated DME totals. Therefore, HSCRC staff anticipates no changes in the DME totals resulting from these recommended changes.

HSCRC staff cannot predict with certainty the impact of the recommended changes to IME. If the one day snapshot in current policy is accurately capturing IME across all hospitals, then the move to FTEs will have little impact. However, if there is currently distortion in the count of residents due to the snapshot, either by unintended occurrence (e.g., seasonal case variability differs among facilities) or design (e.g., manipulation of resident schedules to have in-house rotations align with the snapshot day), then the FTE count will, indeed, result in alterations to the IME counts across facilities. HSCRC staff believes that any impacts resulting from these recommended changes will provide a more complete and equitable view of IME.

Summary of Recommendations

Revised from draft

HSCRC staff received comments or questions from three hospitals on the draft recommendation. Johns Hopkins Health System submitted a letter of support (see Attachment F). University of Maryland Medical System provided verbal comments requesting clarity regarding the calculation of IME, the potential to remove the part time/full time indicator on the IME collection template, and requesting changes to language included in the audit plan. HSCRC staff addressed all concerns. MedStar emailed several general questions, to which HSCRC staff responded.

HSCRC staff recommends the following changes to hospital reporting of GME:

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

Attachment A - Schedule P4A to P4I

SCHEDULES P4A TO P4I - RESIDENTS, INTERNS SERVICES .15

Overview .151

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

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

Attachment A - Schedule P4A to P4I

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

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

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

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

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

Detailed Instructions .152

Heading Section

Institution Name Line

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

Institution Number Line

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

Base Year Line

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

Attachment A - Schedule P4A to P4I

Base Year Data Section

Line A - Base Year Wages and Salaries

Schedule P4A- Columns 1 to 7

Schedule P4B- Columns 1 to 7

Schedule P4C - Columns 1 to 7

Schedule P4D - Columns 1 to 7

Schedule P4E - Columns 1 to 7

Schedule P4F - Columns 1 to 7

Schedule P4G - Columns 1 to 7

Schedule P4H - Columns 1 to 7

Schedule P4I - Columns 1 to 6

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

Schedule P4I - Column 7

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

Line B - Base Year Physician Supervision

Schedule P4A - Columns 1 to 7

Schedule P4B - Columns 1 to 7

Schedule P4C - Columns 1 to 7

Schedule P4D - Columns 1 to 7

Schedule P4E - Columns 1 to 7

Schedule P4F - Columns 1 to 7

Schedule P4G - Columns 1 to 7

Schedule P4H - Columns 1 to 7

Schedule P4I - Columns 1 to 6

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

Attachment A - Schedule P4A to P4I

Schedule P4I - Column 7

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

Line C - Base Year Other Expenses

Schedule P4A - Columns 1 to 7

Schedule P4B - Columns 1 to 7

Schedule P4C and P5C - Columns 1 to 7

Schedule P4D - Columns 1 to 7

Schedule P4E - Columns 1 to 7

Schedule P4F - Columns 1 to 7

Schedule P4G - Columns 1 to 7

Schedule P4H - Columns 1 to 7

Schedule P4I - Columns 1 to 6

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

Schedule P4I - Column 7

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

Line D - Total Base Year Expenses

Schedule P4A - Columns 1 to 7

Schedule P4B - Columns 1 to 7

Schedule P4C - Columns 1 to 7

Schedule P4D - Columns 1 to 7

Schedule P4E - Columns 1 to 7

Schedule P4F - Columns 1 to 7

Schedule P4G - Columns 1 to 7

Schedule P4H - Columns 1 to 7

Schedule P4I - Columns 1 to 6

Attachment A - Schedule P4A to P4I

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

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

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

Line E - Allocation from Cafeteria, Parking, Etc.

Schedule P4A - Columns 1 to 7

Schedule P4B - Columns 1 to 7

Schedule P4C - Columns 1 to 7

Schedule P4D - Columns 1 to 7

Schedule P4E - Columns 1 to 7

Schedule P4F - Columns 1 to 7

Schedule P4G - Columns 1 to 7

Schedule P4H - Columns 1 to 7

Schedule P4I - Columns 1 to 6

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

Schedule P4I - Column 7

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

Line F - Base Year Expenses Adjusted

Schedule P4A - Columns 1 to 7

Schedule P4B - Columns 1 to 7

Schedule P4C - Columns 1 to 7

Schedule P4D - Columns 1 to 7

Schedule P4E - Columns 1 to 7

Schedule P4F - Columns 1 to 7

Schedule P4G - Columns 1 to 7

Attachment A - Schedule P4A to P4I

Schedule P4H - Columns 1 to 7

Schedule P4I - Columns 1 to 6

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

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

FTE Data Section

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

Schedule P4A- Columns 1 to 7

Schedule P4B - Columns 1 to 7

Schedule P4C - Columns 1 to 7

Schedule P4D - Columns 1 to 7

Schedule P4E - Columns 1 to 7

Schedule P4F - Columns 1 to 7

Schedule P4G - Columns 1 to 7

Schedule P4H - Columns 1 to 7

Schedule P4I - Columns 1 to 6

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

Schedule P4I - Column 7

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

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

Schedule P4A- Columns 1 to 7

Schedule P4B - Columns 1 to 7

Schedule P4C - Columns 1 to 7

Attachment A - Schedule P4A to P4I

Schedule P4D - Columns 1 to 7

Schedule P4E - Columns 1 to 7

Schedule P4F - Columns 1 to 7

Schedule P4G - Columns 1 to 7

Schedule P4H - Columns 1 to 7

Schedule P4I - Columns 1 to 6

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

Schedule P4I - Column 7

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

Attachment B - Section 400, Reporting Requirements

OVERVIEW

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

1. ANNUAL REPORTS

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

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

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

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

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

3) Trustee Disclosure Information - Format #11

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

4) Credit and Collection Policy – Format #8

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

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

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

Federal IRS Form 990 – Format # 8

E. Report due June 1 each year

Wage & Salary Report - Format #6

F. Report due December 15th each year

Community Benefit Report – Format #4

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

Schedule IRS – Intern, Residents Survey – Format #4

Attachment C - Schedule IRS Instructions

SECTION 500
REPORTING INSTRUCTIONS
SCHEDULE IRS – INTERN, RESIDENTS SURVEY

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

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

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

Detailed Instructions

Heading Section

Institution Name Line

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

Institution Number Line

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

Period

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

Reporting Section

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

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

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

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

Attachment C - Schedule IRS Instructions

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

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

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

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

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

Revised from draft

Col.9a Patient Care Rotations - Rotation Begin Date - Enter in this column on each line the start date for the intern/resident rotation in which the intern/resident performed patient care activities. Patient care activities included research that is related to the diagnosis and treatment of individual patients.

Col. 9b Patient Care Rotations - Rotation End Date - Enter in this column on each line the end date for the intern/resident rotation in which the intern/resident performed patient care activities. Patient care activities included research that is related to the diagnosis and treatment of individual patients.

Col. 10 Count of Days in Rotation - Enter the count of days in the rotation.

Attachment D - Schedule IRS Template

Revised from draft

HSCRC Schedule IRS - Intern and Resident Survey
Fiscal Yr: FY2012
Hospital Name:

Hospid	Intern/Resident Name (First & Last)	Social Security Number	Name of hospital where intern/resident is employed	Medical School	ECFMG Certificate Date	Program Name	Program Number	Number of Years Completed	Patient Care Rotation		Count of Days in Rotation
									Rotation Begin Date	Rotation End Date	
	Col 1	Col 2	Col 3	Col 4	Col 5	Col 6	Col 7	Col 8	Col 9a	Col 9b	Col 10
#N/A											
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Attachment E - GME Audit Program

GRADUATE MEDICAL EDUCATION AUDIT PROGRAM

APPROVAL OF EDUCATIONAL PROGRAMS

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

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

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

Intern and Resident Information Verification

2. Obtain from the hospital the intern/resident (I/R) documentation for each I/R reported on the HSCRC Intern & Resident Survey (IRS). Hospital documentation should include but not limited to either an intern's resume or residency/program application. Based on review of the intern's resume or application please verify the following:

   Revised from draft

   - Intern/resident name
   - Social Security Number (SSN)
   - Specialty Program
   - Residency Year
   - Previous Specialty Programs
   - Who is paying intern/resident.
   - Intern/resident or "fellow"
   - ECFMG Certificate for foreign medical school graduates

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

Attachment E - GME Audit Program

GRADUATE MEDICAL EDUCATION (GME) RESIDENT FTE COUNT

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

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

Attachment F - Comment Letters

Department of Finance
Johns Hopkins at Keswick
3910 Keswick Road
Suite S4200 D
Baltimore, MD 21211

JOHNS HOPKINS
MEDICINE
JOHNS HOPKINS
HEALTH SYSTEM

Mary Beth Pohl
Deputy Director, Research & Methodology
Health Service Cost Review Commission
4160 Patterson Ave
Baltimore, MD 21215

Dear Ms. Pohl,

I am writing in response to your draft recommendation "Hospital Graduate Medical Education Reporting Changes to Schedules P4A to P4I and Schedule IRS" on behalf of Johns Hopkins Health System hospitals (The Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, Howard County General Hospital and Suburban Hospital Center). Johns Hopkins Health System is supportive of the proposed changes to the reporting of Interns and Residents. Moving to an FTE based count provides a better match between Intern and Resident count with the expense dollars reported by the hospital. Utilizing the existing Medicare reporting structure allows for consistency between both the HSCRC Annual Filing and the Medicare Cost Report data. It is also important to note that as Medicare changes and improves their reporting methodology/requirements, that the HSCRC also follow suit.

Sincerely,

Ed Beranek
Director of Regulatory Compliance
Johns Hopkins Health System

Final Staff Recommendation

Request by the Medical Assistance Program to Modify the Calculation of Current Financing Deposits for FY 2012

February 1, 2012

There was no action taken on this Final Recommendation at the February 1, 2012 Commission Meeting.

Introduction

The Medical Assistance Program (MAP) has been providing working capital advance monies (current financing) to hospitals for many years. As a result, MAP receives the prompt pay discount as per COMAR 10.37.10.26(B). MAP is unique among third-party payers in that it is a governmentally funded program that covers qualified poor residents of Maryland. As such, it deals, to a large extent, with retroactive coverage. Recognizing the uniqueness of MAP, the Commission allowed MAP to negotiate a special formula with the hospital industry to calculate its fair share of current financing monies. The Commission approved this alternative method of calculating current financing at its February 1, 1995 public meeting. Currently, MAP has approximately $94 million in current financing on deposit with Maryland hospitals.

As a result of the state budget crisis, MAP submitted a request on December 19, 2008 that the Commission approve an exception to the requirement that the amount of current financing on deposit with hospitals be re-calculated annually. MAP requested that for one year, FY 2009, the amount of current financing monies on deposit with Maryland for FY 2008 remain unchanged. In its request, MAP stated that it intended to re-institute the annual re-calculation of current financing for FY 2010. The MAP request was approved by the Commission at its January 14, 2009 public meeting.

Because of the continuing budget crisis, MAP submitted a request on February 5, 2010 for modifying the calculation formula. MAP requested that rather than using the approved alternative calculation, which would provide an additional $29.8 million to the $85 million of current financing now on deposit with hospitals, a modified calculation be approved for FY 2010 that would provide an additional $11.3 million. MAP committed to work with MHA's Financial Technical Issues Task Force to review the existent current financing formula with the objective of improving the methodology before the FY 2011 calculation.

In its FY 2011 request, MAP reported that it had met with representatives of MHA several times during 2010, and that they have collectively concluded that any change to the formula would have significant and varying impacts on individual hospitals. Given the continuing state budget constraints, some hospitals could lose much of their current financing deposits. Therefore, they proposed that rather than adopting a new formula, the FY 2011 Medicaid current financing amounts for each hospital be its FY 2010, total increased by the final update factor as calculated by the HSCRC for the current rate setting year. MAP also proposed that changes in the current financing formula be delayed until it replaces its computer system, and its new claims system has been implemented and evaluated.

MAP's request was approved by the Commission at its November 3, 2010 public meeting with the stipulation that MAP be required to report annually on the status of the implementation of its new claims system, and if necessary, to apply for continuation of the application of the HSCRC's update factor to hospital current financing deposits. In addition, the Commission directed MAP and MHA to begin development of a permanent current financing methodology for approval by the Commission for calculating current financing deposits for the first full fiscal year after MAP's new claims system has been implemented.

MAP's Current Request

On December 29, 2011, MAP requested the Commission to again grant approval for an exception to the approved current financing calculation for FY 2012. MAP requested that it be permitted to increase the current financing amounts on deposit with each hospital by the HSCRC's update factor for 2012.

With regard to the status of its new claims system, MAP reported that a recommendation for award will be presented to the Board of Public Works for approval by the end of February 2012.

Staff Recommendation

Based on the current condition of the economy and its effect on MAP's budget, staff recommends that the Commission approve MAP's request staff also recommends that the approval be subject to the requirement that MAP continue to report annually, on the status of the implementation of its new claims system and, if necessary, to apply for continuation of the application of the HSCRC's update factor to hospital current financing deposits for FY 2013.

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Nurse Support Program II
Statewide Initiatives Modifications

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

February 1, 2012

This is a draft recommendation. Comments may be submitted to Oscar Ibarra (oibarra@hscrc.state.md.us) by February 29, 2012.

Purpose

This is a draft recommendation to modify several Nurse Support Program II (NSP II) Statewide Initiatives, last approved by the Commission on December 9, 2009. The proposed modifications, as suggested by the NSP II administrators at the Maryland Higher Education Commission (MHEC), strengthen the NSP II Statewide Initiatives by better supporting nursing faculty development.

The proposed modifications do not alter the percentage of gross patient revenue contributed to NSP II (i.e., the dollars funded for NSP II remain unchanged by these modifications). Additionally, the proposed modifications do not change the Competitive Institutional Grants component of NSP II.

Background

The Health Services Cost Review Commission (HSCRC) approved the creation of NSP II on May 4, 2005, in order to alleviate the critical shortage of qualified nurses in Maryland by expanding the capacity of Maryland nursing schools with specific attention given to educating nurses to become faculty members. The program is funded for up to ten years by a 0.1 percent increase to regulated gross inpatient revenue. NSP II focuses on expanding the capacity to educate nurses through two components, Competitive Institutional Grants and Statewide Initiatives.

The HSCRC contracts with MHEC to administer NSP II. MHEC's duties include developing applications and guidelines, overseeing the review and selection of applicants, conducting site visits, and monitoring and evaluating NSP II. MHEC provides the programmatic and administrative support necessary for the successful administration of the NSP II program.

Recommended Modifications to NSP II Statewide Initiatives

Based on recommendations by MHEC staff, HSCRC staff recommends the following modifications to the NSP II authorized Statewide Initiatives:

- *Graduate Nursing Faculty Scholarships*

  Graduate Nursing Faculty Scholarships are available to eligible students who are sponsored by Maryland higher education institutions to complete the graduate education necessary to become qualified nursing faculty at Maryland institutions. A service obligation is attached to the scholarships.

  - Currently the annual maximum scholarship is $13,000. We recommend modifying the annual maximum award per graduate student to be the amount for tuition and fees at the student's Maryland institution.
  - Currently a scholarship may be awarded only for two years. As nursing institutions are moving toward doctoral-degreed faculty, we recommend removing time limitations around this award to accommodate graduate students pursuing doctoral degrees.
  - Several Maryland institutions have developed nursing education certificates. This credential augments master’s degree prepared students whose studies did not include nursing pedagogy, curriculum development and testing, which undergird sound teaching

methods. We recommend authorizing Graduate Nursing Faculty Scholarships to eligible graduate students pursuing nursing education certificates.

- To commemorate Dr. Harold Cohen's ardent support of NSP and nursing in Maryland, HSCRC staff recommends naming the Graduate Nursing Faculty Scholarships, "The Hal and Jo Cohen Graduate Nursing Faculty Scholarships Program."

- *Living Expense Grants*

  These grants are currently awarded to those recipients of the Graduate Nursing Faculty Scholarship who show need through submission of financial documents. Based on feedback from MHEC staff, HSCRC staff recommends MHEC deemphasizing this component of NSP II.

- *New Nursing Faculty Fellowships* - We suggest no changes to this initiative.

- *Loan Assistance Repayment Program (through the Janet L. Hoffman Loan Assistance Repayment Program)*

  The Janet L. Hoffman Loan Assistance Repayment Program is a separate program from NSP II. We recommend removing the language regarding loan assistance from the HSCRC's NSP II recommendation.

- *Doctoral Dissertation Research Grant*

  As nursing education moves toward more doctoral-degreed faculty, HSCRC staff recommends adding authorization for doctoral dissertation support.

Note, that in addition to these recommendations to the HSCRC, MHEC is recommending to their Commission a number of program modifications, including new applications and guidelines (including application timelines) and additional monitoring processes. MHEC may also place parameters around the authorized initiatives to manage NSP II within the program dollars (e.g., MHEC may set maximum dollars awarded for a scholarship in a given year).

Anticipated Impact of Recommended Changes

HSCRC and MHEC staff anticipate that the recommended modifications to the NSP II Statewide Initiatives will facilitate better preparation of graduate students for teaching and faculty nursing positions in Maryland higher education institutions, including the preparation of more doctoral students. Prioritization of scholarship funding over the living expense grant will provide the financial assistance most needed by nursing graduate students. The scholarship funding carries a service obligation which better addresses the State’s need for doctoral trained faculty and provides stronger accountability for the expenditure of funds.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

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Research and Methodology

December 28, 2011

The Honorable Edward J. Kasemeyer
Chair
Senate Budget and Taxation Committee
3 West Miller Senate Building
Annapolis, MD 21401-1991

The Honorable Norman H. Conway
Chair
House Appropriations Committee
121 House Office Building
Annapolis, MD 21401-1991

The Honorable James N. Robey
Chair
Health and Human Services Subcommittee
3 West Miller Senate Building
Annapolis, MD 21401-1991

The Honorable Mary-Dulany James
Chair
Health and Human Resources Subcommittee
121 House Office Building
Annapolis, MD 21401-1991

RE: 2011 Joint Chairmen's Report, Page 84, M00R01.02 – Health Services Cost Review Commission, Inclusion of Capital Replacement Costs in Hospital Rates

Dear Chair Kasemeyer and Chair Conway:

Pursuant to page 84 of the Joint Chairmen's Report of 2011, the Health Services Cost Review Commission ("HSCRC," or "Commission") respectfully submits this report concerning capital replacement costs. Specifically, the Joint Chairmen's Report requested that the Budget Committees receive a report, prepared in consultation with interested parties, on the inclusion of capital replacement costs in hospital rates (see Attachment I). The Commission established a Work Group of interested parties to address the issues contained in this Joint Chairmen's Report item. After several meetings of the Work Group, the Commission submits the report below.

HSCRC Background

Since 1977, the HSCRC has been responsible for setting hospital payment rates for all-payers in the State of Maryland. This was possible first under a demonstration project waiver from the federal government which allows Maryland to test alternative payment approaches and exempts it from national Medicare and Medicaid reimbursement requirements. Subsequently, in 1980, the Maryland all-payer program was made permanent by federal legislation with the provision that the project continue to meet federal criteria. Hospitals receive an annual "rate order" from the Commission, which establishes the rates hospitals can charge during the fiscal year. Each

hospital charges rates that are tailored to that hospital's unique characteristics and circumstances.

The waiver has made it possible for Maryland to achieve equitable pricing of hospital services for purchasers of care as well as create consistent incentives for hospitals in dealing with the various types of payers. Since all payers must pay commission-approved rates, the program is known as the "all-payer system." Continuation of the waiver is contingent on the all-payer status of the program, as well as on a computation demonstrating that the federal government's payments per case for Medicare in Maryland have not risen more rapidly over time than in the rest of the country. In Maryland, this is known as the "waiver test."

In setting hospital payment rates, the Commission must carefully balance the need to keep effective and efficient hospitals financially solvent, while, at the same time, making quality hospital care more affordable and accessible. In order to reach this balance, one of the factors that the Commission considers in the approval of rates is the cost of hospital capital projects.

The Certificate of Need Process

Many hospital capital projects are first reviewed by the Maryland Health Care Commission ("MHCC") through the Certificate of Need ("CON") process. The Maryland Certificate of Need ("CON") program is intended to ensure that new health care facilities and services are developed in Maryland only as needed and that, if determined to be needed, that they are:

- The most cost-effective approach to meeting identified needs;
- Of high quality;
- Geographically and financially accessible;
- Financially viable; and
- Will not have a significant negative impact on the cost, quality, or viability of other health care facilities and services.

The CON program functions by requiring review and approval of certain types of proposed health care facilities and service projects by the MHCC. Approved projects are awarded a CON authorizing the project applicants to implement the project within the approved spending level and on a timely basis. The policy objectives and standards established by the MHCC in the State Health Plan provide the basis for review of proposed projects. With certain exceptions, a CON is required to:

- Build, develop, or establish a new health care facility;
- Move an existing health care facility to another site;
- Change the bed capacity of a health care facility;
- Change the type or scope of any health care service offered by a health care facility; or

• Make a health care facility capital expenditure that exceeds a threshold established in Maryland statute (currently just under $11 million).

Regulations require that the MHCC consider six criteria in its review of CON applications. These criteria include the availability of financial and nonfinancial resources, including community support necessary to implement the project within the time frames set forth in the MHCC's performance requirements, as well as the availability of resources necessary to sustain the project. It is at this point in the process that the HSCRC evaluates the financial impact and viability of proposed capital projects and shares such information with MHCC to assist with a determination.

Hospitals may request additional funding in rates for expenses related to capital projects (depreciation and interest on project debt) if they obtain CON approval for the capital project. Hospitals can avoid the necessity for CON review and approval of some capital projects that would otherwise require approval by taking the "Pledge." In taking the "Pledge," a hospital documents to MHCC that the capital project does not contain any elements that categorically require CON approval independent of the project cost, and that the only requirement for CON review and approval is that the project cost exceeds the spending threshold requiring a CON approval (currently $10.95 million). The hospital can obtain a determination of coverage that CON approval is not required if it pledges not to request an increase in rates from the HSCRC greater than $1.5 million associated with the capital project over the life of the project. Most hospitals seeking CON approval of capital projects in recent years have not projected a need for adjustments in rates by HSCRC as necessary or planned for at the time the CON application is filed; however most also state that they reserve the right to seek rate adjustments if necessary.

When hospitals choose to fund projects through their existing rate structure a hospital may seek a "Comfort Order" from the Commission. Non-profit hospitals generally finance major capital expenditures through the issuance of tax-exempt bonds. The Maryland Health and Higher Educational Facilities Authority ("MHHEFA") is the primary bonding source for Maryland hospitals. It was created in 1970 to assist non-profit hospitals and educational institutions in financing construction and acquisition of their facilities at the least cost to the users. In order to access the tax-exempt markets at reasonable rates, hospitals must demonstrate sufficient credit-worthiness to obtain investment grade ratings or some form of credit enhancement permitting the sale of the bonds. The bond markets determine creditworthiness of non-profit hospitals principally by evaluating the ratio of anticipated cash flow to annual debt service, the proportion of debt in the hospital's capital structure, and the level of cash balances.

Traditionally, lenders in the market have viewed the revenues of regulated entities as fixed and, at least partially, beyond the control of the issuing party. In this sense, there is concern that regulation, in a generic way, may restrict the timely reaction to market and environmental factors and thereby limit profitability. MHHEFA requires that the HSCRC issue a "Comfort Order" to provide a level of assurance or comfort that there remains sufficient liquidity within the hospital's rate structure as approved by the HSCRC to pay bond holders over the life of a particular debt issue. In combination with the stability of the rate system as well as the added security of the Maryland Bond Indemnification Program, Comfort Orders have benefited Maryland hospitals by reducing capital costs; by enhancing bond ratings; and by increasing

access to the Credit Markets.

How Capital Costs Are Incorporated in Hospital Rates

Capital costs have been included in hospital rates through various mechanisms in the Commission's rate methodologies: (1) in the base rate structures of hospitals, included permanently, and updated each year by the update factor; (3) in the annual market basket projection; (4) through periodic targeted policy increases for capital or technology; or (5) in the scaling of the update factor based on efficiency or reasonableness of charges which includes a factor for capital costs.

It is important to note that there are no restrictions on how any amounts in rates designed for capital or otherwise shall be used. Some hospitals have used additional revenue toward their capital programs, while others have used it for other purposes.

Capital Costs in Base Rates

In the late 1990's, the Commission adopted a Charge-per-Case system which establishes a per-case target that hospitals are to meet for the rate year. Hospitals continue to charge on a fee-for-service basis, but costs are constrained by the charge-per-case target. Under this system, the base rates are adjusted by an update factor and by a hospital's case-mix. When the Commission moved to the Charge-per-Case structure, it included all of the built-in costs within the previous rate structure, including a reasonable amount for capital costs. The amount included in the base rates remains in rates permanently and is compounded by subsequent update factors.

Market Basket Component of Update Factor Includes Capital Costs

In addition, each year the Commission considers the percentage by which hospital rates will be updated in the upcoming fiscal year. Since rates are set prospectively, a key component of the update factor is the forecast of the expected Market Basket costs. The Market Basket is a fixed-weight index that measures price changes in the underlying factor inputs used in the hospital production process. The primary factors in the Market Basket include wage growth, supplies, capital (including construction costs and equipment), and contractual services. This is the same Market Basket component used by Medicare in the calculation of its annual update effective October 1st of each year. The Market Basket estimate per HSCRC policy is determined by the most recent Global Insight's publication available. Global Insight Inc. is a respected economic forecasting firm with the detailed macroeconomic and industry knowledge and expertise needed to forecast the price series in the Market Basket. Forecasts are available for a 10-year period.

Periodic Policy Adjustments

Previously, the Commission made policy adjustments to the update factor to permit hospitals to take advantage of favorable financing markets for capital projects. The primary components of the update factor each year include:

- Forecasted Market Basket Inflation – as discussed above;
- Market Basket Forecast Error Adjustment – to reflect the historical margin of market basket forecasting error, or the normalized difference between a forecast amount and actual;
- A Policy or Productivity Adjustment – (see below);
- Rate "Slippage" – an estimate of deviations from approved revenue growth as a result of other features of the rates setting system such as rate increases granted through full rate reviews, the impact of "Spend-down" agreements, or other factors such as variations from previous years' volume adjustments;
- Case-mix provision – takes into account the annual increases in measured additional resource use due to increases in intensity of care and/or patient severity of illness year to year;
- Volume adjustment – reflecting Commission policy regarding recognition of the fixed and variable component of hospital costs.

In past years, the HSCRC update has contained either a reduction to trend as a means of constraining revenue growth and hospital cost growth (productivity factor), or additions to trend to help improve the financial condition of the hospital industry. Accordingly, the magnitude of the Policy/Productivity adjustment has varied over the years. During FYs 2004-2006, the policy adjustment was of a positive magnitude and ranged between +1 to 2% each year. These additions to rates were intended to help hospitals build profitability in order to facilitate a large recapitalization of the industry.

Between 2001 and 2010, there have been more than $6.9 billion expended in hospital capital projects (See Attachment II). Of this amount, approximately $5.9 billion was spent on CON approved projects, and $1 billion on projects in which hospitals took the "Pledge" or where no CON was required. Of the $5.9 billion in CON approved projects, hospitals received additional funding in hospital rates through either the partial rate review or full rate review process, or were approved for "forward funding" by the Commission.

Attachment III shows that the bulk of capital projects over the past 10 years occurred during 2005, 2006, and 2007 - after the Commission included additional amounts in the annual update factor to allow hospitals take advantage of favorable financing (See Attachment III). Approximately $4.4 billion of the $5.9 billion in CON approved projects (described above) occurred during this period.

Scaling of Update Factor Based On Reasonableness of Charges

After the standard update factor is determined based on the components listed above, an adjustment is made to each hospital based on its efficiency in accordance with the Commission's Reasonableness of Charges ("ROC") methodology. In FY 12, update factors were adjusted up or down by 15% of the difference between a hospital's position on the ROC and the peer group average.

The ROC is intended to allow hospitals to be compared on an equal footing to determine if a hospital's charges are reasonable relative to other peer hospitals in the State. The ROC is a central element of the Commission's mission to promote cost effective and efficient hospital services in Maryland. It also provides feedback to hospitals on their performance relative to their peers.

The ROC uses each hospital's charge per case and compares it to their peers. The Commission recognizes five defined peer groups. This methodology makes adjustments for costs (or elements of charges) that are beyond the control of the hospital. Those adjustments include costs associated with labor market, graduate medical education, case mix, disproportionate share, and capital costs.

The capital cost adjustment takes hospital capital depreciation, interest, and capital lease costs as a percentage of total costs. The ROC charges are then adjusted by taking the sum of one half the hospital's capital costs plus one half of the hospital's peer group average capital costs. The effect of this adjustment is to improve a hospital's relative position on the ROC at the beginning of its capital cycle when capital costs are high, and, conversely, a hospital with low capital costs would see its ROC position deteriorate.

In essence, this adjustment can mitigate the potential negative impact that high capital costs could have on a hospital's update factor scaling. By virtue of this adjustment, hospitals with higher capital costs than their peers will appear to be lower cost than without the adjustment.

Options for Obtaining Additional Capital in Rates

When undertaking major capital projects, hospitals may attempt to obtain additional revenue to fund capital through one of two mechanisms: (1) Full Rate Review; or (2) Partial Rate Review for Capital.

A hospital, or the Commission, may initiate a full rate review to determine whether the overall rates of a hospital should be increased or reduced. The full rate review process is viewed in two phases. The first is a formula and technical calculation and comparison. This formula is very similar to the ROC methodology; however, the full rate review process also strips out profits. The Commission's standard for permitting an increase in rates is for the subject hospital's costs to be 2% below the peer group average plus the average profit margin of the peer group.

The second phase of the full rate review process permits hospitals to justify cost factors that should be viewed outside the formula due to unique circumstances.

In addition to the full rate review, a hospital may submit a less restrictive partial rate application exclusively for capital needs. In recognition of the need for significant recapitalization in the industry, in October of 2003, the Commission instituted this partial rate application process. This policy looks only at capital needs and considers 50% of the hospital's capital needs and 50% of its peer group average. In this way, the policy acknowledges the specific needs of the subject hospital but moderates the allowance by factoring in the peer group average as a "reasonableness" barometer. The Commission considers the costs of depreciation and interest for the first full year that the project begins operations.

When hospitals are successful at obtaining additional funding through a full rate review or partial rate review process, the update factor is adjusted in the next year to ensure that these costs are revenue-neutral to the system overall. Thus, the update factor will be reduced by the total amount of additional capital costs rewarded through these processes. This is known as "slippage."

Neither of these processes (full or partial review) takes into account any funds that hospitals are able to generate outside of the rate structure. Many hospitals raise money through philanthropy to cover a portion of the costs of a capital project. Some hospitals obtain legislative approval to receive money through the State's capital budget as well. The Commission does not offset these revenue sources when determining whether or not a hospital is eligible for capital funding.

Since 2001, the Commission has provided hospitals with additional revenue through hospital rates to fund capital projects through the following mechanisms (See Attachment II):

- 6 hospitals obtained additional funding through the partial rate application process;
- 4 hospitals obtained additional funding through full rate reviews; and
- 4 projects through a one-time policy of "forward funding."

In June of 2009, the Commission adopted a one-time "forward funding" policy, which was a less restrictive variable cost factor designed to fund capital projects in place of funding capital through rate increases. In FY 2008, the Commission moved from a 100% variable cost factor to 85% - meaning that rates will reflect 85% of additional volume. This change recognizes that costs do not increase 100 cents on the dollar with volume changes. In the 1990s, the Commission employed a variable cost factor less than the current 85%.

In 2009, the Commission adopted the forward funding policy to allow eligible projects to receive a different variable cost factor for three years after first use of a newly constructed facility. If a CON was filed and approved, along with the related Comfort Order, under the 100% variable cost policy, it was assumed the incremental margin on additional volume could be used to help fund the capital requirements. When the HSCRC changed the variable cost policy to 85%, this restricted hospitals' ability to generate incremental margin on additional volume. By implementing this policy change, the Commission recognized the difficulty faced by hospitals that undertook major capital projects just prior to the Commission's decision to move from a 100% variable cost adjustment to the more restrictive 85%.

Many Projects Funded through Profitability, Efficiencies and Volume

Hospitals rarely use the full or partial rate review process to obtain additional funding for capital. Instead, they take the "Pledge" that they can finance the project through their existing rate structures or, if CON approval is required, they anticipate being able to fund higher depreciation and interest expenses through normal updates in rates and volume growth. These projects are typically funded through existing profitability and efficiencies accrued from placing the capital projects into service.

Under the Charge per Case system, hospitals can achieve additional profits if the underlying costs of the services provided by the hospitals are less than were expected when the charge per case was established at the beginning of the year. Hospitals possess many tools to achieve these efficiencies. One is to provide the services with lower resource use. This in essence relates to creating more efficiency in the provision of the health care services. Another budgeting tool used by hospitals is to reduce administrative costs such as personnel, overhead, and housekeeping services.

Hospitals may also accrue additional revenue to enhance profitability through increased volume or market share. A common way of doing this is to increase volume market share for a particular service. Increased market share can increase volume and revenue over the previous year. However, as described above, the Commission limits the amount of additional revenue hospitals get to "keep" to 85 cents on the dollar. Current Commission policy is to recognize hospital costs as 85% variable. As volumes grow, hospitals obtain additional revenue. This adjustment is symmetrical (i.e., if volumes decline, hospitals only lose 85 cents on the dollar, and the volume adjustment in a subsequent year will be positive).

New capital projects tend to facilitate a hospital's ability to reduce costs through design efficiencies or the enhanced attractiveness of their facilities for physicians and patients, which allows them to boost market share for certain services. The additional profits achieved can be utilized to cover additional costs associated with depreciation and interest.

However, as noted above, the Commission uses a macro-economic approach to rate setting and does not dictate how hospitals expend their resources. HSCRC data show that hospitals have become increasingly challenged by unregulated costs. The most significant of these relate to providing subsidies to physicians and physician practices. Hospitals have reported losses of $307 million in FY 2010 as a result of unregulated physician costs.

The HSCRC incentives for volume are changing. In the spirit of national health care reform, the Commission has begun implementing bundled payment strategies under its existing authority to align payment incentives in a manner that encourages clinical integration of care. In FY 2011, the Commission signed agreements with 10 hospitals under global budget incentives, called Total Patient Revenue ("TPR") arrangements. These 3-year TPR arrangements between the Commission and individual hospitals are voluntary and establish fixed global (and guaranteed) revenue levels for hospitals for all inpatient and outpatient revenues regardless of volumes. These arrangements are most applicable to more isolated rural facilities with defined catchment areas. The global budget under this strategy includes all inpatient and outpatient revenue regulated by the Commission.

The Commission is also currently implementing a new bundled payment strategy for FY 2012 based on an Admission-Readmission Revenue ("ARR") structure. This involves an expansion of the "guaranteed inpatient revenue" rate constraint concept by expanding the episode payment constraint from a per case basis to include both admissions and readmissions over 30 days. The Commission has signed 31 voluntary agreements with Maryland hospitals under this payment structure.

These structures provide new tools to hospitals for creating profitability. As hospitals reduce

unnecessary admission and readmissions, they will retain the revenue amounts for these services generated in previous years. The savings will accrue to the hospital, increasing profits to be used for additional infrastructure and other costs including capital and information technology.

Calculation of Capital Expenses and Capital Amount in Rates

HSCRC staff conducted an analysis of hospitals' depreciation and interest costs (See Attachment IV). The total amount of depreciation and interested (capital) expenses reported to the Commission by hospitals in FY 2010 was $941.4 million, or an average of 8.73% of FY 2010 gross patient revenue. This percentage varies by hospital.

The calculated percentage that depreciation and interest costs represent of total costs in FY 2010 was spread across all hospital rate centers in Maryland (or rate realigned) when determining rates for FY 2012. Therefore, hospital rates for FY 2012 include $1.26 billion associated with depreciation and interest.

It is important to note that while the Commission uses the prior year's depreciation and interest costs to realign rates in future years, it does not dictate that this portion of revenue be used for capital costs in those years.

Comments from Interested Parties

The Commission conducted several meetings with interested parties in order to meet the charge set out in the Joint Chairmen's report. Below are the points made by hospital and payer representatives regarding this capital costs.

Hospital Representatives

- HSCRC policies are no longer viable sources to support hospitals' capital replacement, expansion, and information technology upgrades.

  The HSCRC provided several mechanisms for hospitals to fund capital costs: (1) annual rate updates to cover operating and capital cost inflation increases; (2) special rate adjustments to cover a portion of a hospital's depreciation and interest costs; (3) rate adjustments through the Reasonableness of Charge analysis; and (4) the ability to generate a profit margin as service utilization increased. Changes in the healthcare marketplace have eroded the efficacy of each of these mechanisms to fund Maryland hospitals' capital needs.

  - Annual rate updates to cover capital and operational inflation

    As Medicare payments nationally are constrained, and additional pressure is placed on Maryland's Medicare waiver, annual increases to Maryland hospitals have recently declined below inflation. Information Technology costs, which include both capital expenditures and operational costs, are a growing portion of hospital expenses. Information Technology infrastructure is critical for enabling improvements in care

transitions, reducing patient harm, reducing avoidable readmissions and supporting better outcomes. These new costs are not recognized in estimates of healthcare inflation. In other states, hospitals are able to continue operating with Medicare reimbursement below cost by receiving higher reimbursements from private payers; Medicare costs are shifted onto the private payers.

- Special rate adjustments to cover a portion of depreciation and interest costs

  The full and partial rate review processes set a rigorous standard for a hospital to qualify for a capital-related rate increase. The hospital's adjusted charges must be approximately 5-7 percent below their peer hospitals' average adjusted charges. Since 2006, only four hospitals received rate increases through the full rate review process, and a handful of additional hospitals qualified for additional funding through the partial rate review process. The hospital receiving adjustments had less than 50 percent of the incremental capital costs included, and in most cases far less than 50 percent of its incremental capital costs included in rates.

- Reasonableness of Charges Scaling

  HSCRC adjusts hospitals' annual rate increase based on a Reasonableness of Charges tool that compares hospitals' charges after adjusting for factors that are known to influence rates such as the labor market, patient characteristics, etc. The HSCRC methodology recognizes a portion of each hospital's capital costs in this comparison and favorably adjusts the hospital's charges so that the hospital is more likely to compare favorably to others and receive a favorable rate adjustment. The HSCRC approved the phasing out of capital recognition in the Reasonableness of Charges analysis beginning in 2012.

- Growth in utilization of hospital services has been the most widely used mechanism to fund hospitals' capital needs.

  Hospitals with strong volume growth and disciplined expense control were able to build reserves and fund capital projects without additional rate increases specifically for capital projects. The variable cost factor policy, implemented in 2009, was the first of several HSCRC policies to provide an incentive to restrain volume growth. Two payment arrangements--Total Patient Revenue and Admission Readmission Revenue--now in place at 41 of the 46 acute care hospitals, provide strong incentives to avoid volume growth. Maryland hospital admissions declined more than 1 percent in fiscal year 2010, more than 4 percent in fiscal year 2011, and are continuing to decline in fiscal year 2012. The transition toward healthcare payment policy that rewards value, not volume, moves Maryland in the right direction. At the same time, it requires new mechanisms to fund capital replacement and information technology needs.

Payer Representatives

- Capital portion of market basket is adequate to cover capital costs.

  The market basket amount in the HSCRC base update factor is adequate to recognize increases in capital costs in Maryland. According to Medicare, the average composite life of a capital asset is about 17 years. This means that roughly 6% of capital depreciates every year on average. According to Moody's Investor Services, rated hospitals spend, on average, about 120-130% of their depreciation on asset purchases per year (125% is used for this example).

  If a hospital has an asset base of about $125,000,000 and depreciation of $20,000,000 at the start of the year, after 6% depreciation, the hospital would be left with $18,800,000 in depreciation. However, by purchasing 125% of the $1,200,000 in depreciation, their depreciation would go up by $1,500,000, resulting in an end of year depreciation of $20,300,000. This represents a 1.5% increase ($20,300,000/$20,000,000), which is about what the capital portion of the market basket is each year.

  The 125% of capital purchases used in this example is not only for replacement but also for new equipment (such as for a 5th CAT scanner and not a replacement for the 4th), so the 125% may actually overstate replacement costs. The capital cost index in the market basket varies from the 1.5% from year to year (usually based on the interest market), but the update finances at least the average cost of maintaining and replacing a hospital's asset base.

  In addition, based on Medicare cost reports, 7.5% of Medicare costs reflect the cost of capital. Attachment IV shows that under the all payer system, based on what hospitals reported for FY 2010, 8.73% of gross patient revenue at Maryland hospitals reflects the cost of capital. Therefore, Maryland hospitals have a higher percentage of capital costs than the nation's hospitals have on average.

- Processes for obtaining additional capital should be restrictive to address special circumstances.

  The capital provisions in rates were never intended to provide funding for all capital costs for all projects. The rate structures of hospitals have been significant enough for hospitals to generate reasonable profits over the years, even in recent years with economic and financing challenges as well as with reduced update factors. As hospitals do nationally, hospitals in Maryland also use other means to fund capital projects:

  - Profit margins accrued by operating efficiently and effectively under the rate structure approved by the Commission.

    In FY 10, the average regulated hospital operating profit margin was 6.22%. This represents profits accrued on services provided by the hospital under the regulatory jurisdiction of the HSCRC. After factoring in margins on unregulated services and non-operating factors, the hospital combined operating profit margin was 2.6%.

Likewise, in FY 2011 (estimated), the regulated operating margin was 7.57%, and the combined regulated and unregulated operating margin was 3.14%.

Hospitals are generating high profits on regulated revenue – 6.22% in FY 10 and 7.57% in FY 11. This means that hospitals are achieving significant regulated profits over and above costs, and those costs include all capital costs. Therefore, hospitals have the resources under the Commission's existing policies to fund capital projects through rates and margins.

The primary driver in the difference between the regulated and unregulated margins is hospitals' investment in physician practices – services that are not regulated under HSCRC jurisdiction. These investments are business decisions of hospitals just as those decisions related to hospitals' investment in capital projects.

Maryland hospitals have indicated that absent the all payer system in Maryland, they could shift costs to obtain additional revenue to fund capital costs. This is an unrealistic assumption. Hospitals have limited ability to increase payments from public and private payers nationally. If cost shifts were to occur, they would fall predominantly on those who can least afford it – the uninsured.

- Philanthropy and funding through the State Capital budget

Many hospitals obtain additional funding through philanthropic contributions. The Commission does not take these contributions into account when it considers how much capital is in rates, nor is it considered during the course of a full or partial rate review. Likewise, when hospitals receive capital funding either through the legislatively approved bond bills or the State's capital budget, the Commission does not reduce their request by this amount during the rate review processes.

- Offsets to Higher Capital Costs Achievable Through Major Capital Projects

Hospitals that undertake major capital projects, involving expansion or replacement of building space, have opportunities to redesign significant departmental space. This provides the opportunity for hospitals to incorporate design features that increase operational efficiency. Because of unsustainable increases in hospital cost, efforts to boost productivity by reducing labor cost per unit of service through design changes are imperative whenever hospitals implement major expansion or renewal projects. The two chief cost-saving approaches seen in recent projects are:

1. Realignment of departmental adjacencies, which tend to reduce efficiency over time as hospitals are incrementally expanded and reconfigured. Major projects allow for a rational reorientation of many or, sometimes, all of a hospital's diagnostic, treatment, and support components, which can create large opportunities for staffing efficiencies in the areas of patient transport and supply distribution; and

2. Standardization of room and unit design, furnishing, and equipage, enhancing flexible use of staff across multiple units and providing other economies in maintenance and technical support;

Additionally, large long-term savings can be achieved when older building systems, and the older buildings they support, are replaced and modernized. Higher energy costs are a major inflation factor for the high energy use businesses such as hospitals. Furthermore, the waste stream of the hospital can also be reengineered when major campus projects occur. While environmental protection regulations drive some of these changes, the hospital can more easily incorporate major changes in waste disposal and recycling systems when large scale projects are undertaken that will save money over the life cycle of the buildings, given that waste disposal costs will continue to increase. These changes may require higher levels of investment up-front but more than pay for themselves over time.

- As volume declines, the State should re-evaluate whether more hospital beds are needed throughout the State.

  Over the past two years, data show that inpatient admissions are declining. This trend began in December 2010 and has continued. Admission declined by 4.02% during the 12 month period between August 2010 and July 2011. As this trend persists, the Maryland Health Care Commission should re-evaluate whether there is excess bed capacity in the State. The MHCC could use other states, like Virginia, for comparison purposes.

- Depreciation and interest costs

  Depreciation and interests costs (those capital costs considered by the Commission) are calculated during first full year that the project is placed into use. The actual depreciation and interest costs vary over the life of the project based on financing arrangements and other factors. Therefore, it would be most accurate, for the rate setting purposes, to use the average depreciation and interest over the life of the project.

- The 85% volume adjustment is generous

  As stated in the report, the Commission's variable cost factor is 85%, meaning that hospitals receive 85 cents on the dollar for additional volume. In the 1980's, the Commission used a variable cost factor that varied based on the percentage of increase in volume. At some levels, the variable cost was less than 85%. While literature indicates that 85% is a reasonably average variable cost factor, it can be generous to some hospitals especially as volume increases as a result of a new project.

- Any additional amount added to rates for capital will negatively impact on a declining Medicare waiver test.

  Maryland maintains the Medicare waiver to set hospital rates for all payers provided two requirements are met. One is that the system remain all- payer, and the second is a test that

compares Maryland's rate of growth in Medicare payment per case since 1980 to the nation. The current waiver letter using data ending September 30 2010 shows a relative cushion of 9.55%. This is down from the June 30, 2010 cushion of 10.40%. The HSCRC prefers to maintain at least a 10% differential and considers the 7% mark a call for corrective action. Given expected Medicare and HSCRC payments and the implementation of bundled payment structures, the waiver cushion is expected to decline to below the 7% level.

Any additional funding provided in rates for other purposes, such as capital (or Medicaid deficits), has a direct impact on the slope of this waiver cushion trend.

Conclusion

The HSCRC includes a significant amount of capital costs in rates. Hospitals, under specified circumstances, may obtain additional revenue through rates to cover capital costs by using either the full rate review or partial rate review process. However, hospitals rarely use these mechanisms because they do not qualify.

With the advent of bundled payment structures that encourage reduced admissions and readmissions it may be necessary for the Commission to revisit some of its capital methodologies in the near future. However, since there is a lag in data associated with the Commission methodologies, it likely would be one to two years before these volume trends would be realized in these methodologies. The Commission has begun discussions with interested parties to consider potential changes to the capital policies moving forward.

Thank you for this opportunity to elucidate the Commission's policies relating to capital costs and to share the views of interested parties regarding these policies.

Sincerely,

Stephen M. Ports
Acting Executive Director

Attachment I

M00R
Department of Health and Mental Hygiene
Health Regulatory Commissions

Committee Narrative

HEALTH REGULATORY COMMISSIONS

M00R01.02 Health Services Cost Review Commission

Inclusion of Capital Replacement Costs in Hospital Rates: The committees are interested in the feasibility of including capital replacement costs in hospital rates set by the Health Services Cost Review Commission (HSCRC). To that end, the committees direct HSCRC, in consultation with interested parties, to submit a report concerning the inclusion of capital replacement costs in hospital rates. For purposes of this report:

- Capital replacement expenditures means expenditures by a facility made in accordance with, and in an amount not exceeding, an approved certificate of need from the Maryland Health Care Commission to replace existing hospital capacity, including inpatient facilities and necessary support services;

- Capital replacement expenditures includes non-patient care operational expense increases resulting from costs associated with the replacement facilities such as increased depreciation, interest and energy and housekeeping expenditures related to increased square footage required to meet current hospital standards of patient safety, construction and operation; and

- Capital replacement expenditures do not include expenditures made to increase licensed bed capacity at a facility or expenditures made by a facility for capital replacement for projects placed in service prior to July 1, 2010.

Information Request	Author	Due Date
Inclusion of capital replacement costs in hospital rates	HSCRC	December 15, 2011

Attachment II

CON Capital Expenditures with/without Approved Rate Increases

FY 2001 through FY 2011

	CON Pledge or No CON Required	CON Approved with No Increase to Rates	CON Approved with Increase to Rates	Method of Additional Rate Increase
Acute Care Hospitals				
Anne Arundel	$80,966,550	$5,243,815	$274,365,060	Partial Rate Application
Carroll County	$15,000,000	$29,239,750	$27,950,000	Partial Rate Application
Cecil			$22,903,039	Partial Rate Application
Civista			$79,854,825	Partial Rate Application
Meritous			$346,598,506	Partial Rate Application
Western Maryland	$16,693,000		$400,207,650	Partial Rate Application
Calvert			$32,674,427	Full Rate Application
Dorchester			$4,287,520	Full Rate Application
Easton			$34,649,988	Full Rate Application
Hopkins	$114,311,994	$73,647,006	$1,306,543,490	Full Rate Application
BWMC	$15,560,000	$36,546,000	$134,607,479	Forward Funding
Franklin Square	$9,858,769		$224,878,180	Forward Funding
Mercy	$132,720,259	$5,720,000	$571,894,523	Forward Funding
St Agnes	$4,552,500	$14,913,000	$214,931,000	Forward Funding
Atlantic General	$4,800,000			
Hopkins Bayview	$5,010,000	$48,251,771		
Bon Secours	$8,300,000			
Chester River	$6,000,000			
Doctors	$13,200,000	$69,045,019		
Fort Washington	$11,467,540	$57,738,000		
Frederick	$17,895,830	$82,292,963		
Garrett	$8,740,000			
GBMC	$1,422,960	$42,610,525		
Good Samaritan	$18,499,200	$12,500,000		
Harbor	$5,000,000			
Harford	$10,500,000	$2,443,755		
Holy Cross	$9,445,776	$490,250,144		
Howard County		$105,000,000		
Kernan				
Laurel				
Maryland General	$1,450,000	$57,615,543		
McCready				
Montgomery		$48,910,408		
Northwestern	$17,924,638			
Peninsula Regional		$131,899,948		
Prince Georges	$4,025,000			
Shady Grove	$11,458,000	$98,954,260		
Sinai	$118,495,323	$21,907,540		
Southern Maryland	$2,500,000	$43,516,251		
St Joseph	$121,850,000			
St. Marys	$26,190,000	$60,460,059		
Suburban	$21,557,216	$18,617,820		
Union Memorial	$16,373,932			
University	$89,444,023	$533,897,000		
Upper Chesapeake	$65,941,345	$52,149,924		
Washington Adventist	$5,200,000			
Other Hospitals				
Kennedy Krieger	$12,000,000	$5,500,000		
Spellman		$32,684		
Kessler Rehab		$355,000		
Potomac Ridge		$1,194,619		
Brook Lane	$3,650,000			
Clifton Perkins		$19,815,968		
Sheppard		$86,328,580		
Mt Washington	$3,000,000			
Totals	$1,031,003,855	$2,256,597,352	$3,676,345,687	
All Total			$6,963,946,894	

Attachment III

Hospital Capital Projects by Fiscal Year

	CON Pledge or No CON Required	CON Approved	
FY 2001	$125,374,577	$82,145,963	
FY 2002	$194,645,800	$71,825,275	
FY 2003	$37,594,400	$116,091,176	
FY 2004	$135,503,200	$166,170,554	
FY 2005	$122,402,575	$1,926,919,426	
FY 2006	$146,909,916	$1,321,109,974	
FY 2007	$132,712,042	$1,153,805,392	
FY 2008		$323,641,694	
FY 2009	$54,920,000	$88,422,927	
FY 2010		$234,107,801	
FY 2011	$80,941,345	$448,702,857	
Total	$1,031,003,855	$5,932,943,039	$6,963,946,894

Attachment IV

Analysis of Capital In Rates for FY 2012

Based on FY 2010 Cost Report

Units #	Direct Patient Care Expense	Patient Overhead Expense	Other Overhead Expense	Schedule P2 Cost	Schedule P4 Cost	Total Level 1 Expense	Building Expense	Equipment Expense	Total Level 2 Expenses	Capital Cost	Capital Percent	Estimated Gross Revenue FY 2012	Capital in Rates	Approved Mark up	Cost Included in Rates Per Yr	Direct Other Financial Consideration	Percent Other Financial Consideration	Total Level 3 Expenses	Payer Differential	Total Level 4 Revenue
MERITUS	142,501.6	27,237.6	28,363.7	0.0	0.0	198,102.9	10,388.6	2,515.9	211,007.5	12,904.5	6.12%	281,283.1	17,202.3	1.123819	$15,307.0	0	-2256.1	208751.3	29780.5	238531.8
UNIVERSITY OF MD.	482,721.0	87,022.4	86,376.3	0.0	57,540.1	713,659.8	79,234.9	8,514.5	801,409.3	87,749.4	10.95%	1,136,506.8	124,440.5	1.130333	$110,091.9	0	6294.3	807703.5	115175.4	922878.91
PRINCE GEORGE	131,550.6	25,477.6	35,898.9	2,737.0	3,729.4	199,393.5	9,255.1	1,078.3	209,726.9	10,333.4	4.93%	288,456.8	14,212.5	1.209145	$11,754.2	0	542.6	210269.5	49232	259501.48
HOLY CROSS	181,575.3	38,399.7	60,641.6	2,765.9	2,405.8	285,788.3	23,955.7	3,956.8	313,700.8	27,912.5	8.90%	439,274.1	39,085.8	1.118142	$34,956.0	0	-10937.1	302763.68	39592	342355.68
FREDERICK MEM.	144,928.0	21,874.1	41,339.0	0.0	0.0	208,141.1	20,151.1	3,905.3	232,197.5	24,056.4	10.36%	324,211.0	33,589.3	1.100993	$30,508.2	-6260.6	7037.9	232974.8	24652.7	257627.48
HARFORD MEM.	43,901.3	10,179.9	14,802.4	0.0	0.0	68,883.7	5,180.0	715.4	74,779.0	5,895.4	7.88%	107,961.1	8,511.4	1.144956	$7,433.8	0	-732.2	74047	12450.3	86497.13157
ST. JOSEPH'S	197,345.5	29,916.9	48,550.8	200.6	0.0	276,013.8	21,597.7	3,509.3	301,120.8	25,107.0	8.34%	359,137.2	29,944.3	1.076836	$27,807.7	0	-4125	296995.7	29345.8	326341.5
MERCY	179,031.8	36,667.6	52,740.5	5,577.2	4,546.3	278,563.5	26,479.8	4,218.0	309,261.3	30,697.8	9.93%	422,954.3	41,983.2	1.117367	$37,573.3	0	-405.5	308855.8	42475.8	351331.57
JOHNS HOPKINS	896,017.3	153,389.8	186,902.6	20,724.2	64,769.3	1,321,803.2	94,750.5	9,434.1	1,425,987.9	104,184.6	7.31%	1,813,981.3	132,532.0	1.094277	$121,113.7	-21069.54	-4699.13	1400219.2	119060.9	1519280.1
DORCHESTER GEN.	23,000.4	4,600.4	10,773.2	0.0	0.0	38,374.0	2,801.2	900.4	42,075.6	3,701.6	8.80%	57,655.0	5,072.2	1.121988	$4,520.7	0	444.6	42520.2	4476.3	46996.5
ST. AGNES	167,765.6	26,861.9	54,720.8	3,816.9	6,938.2	260,103.5	14,874.1	3,727.6	278,705.2	18,601.7	6.67%	381,865.5	25,487.0	1.120109	$22,754.0	0	-27481.2	251224	30142.3	281366.31
SINAI	308,004.4	50,391.0	65,822.9	6,462.6	14,312.6	444,993.5	46,326.5	6,601.4	497,921.5	52,927.9	10.63%	650,392.9	69,135.3	1.112834	$62,125.5	-5441	-8594.7	483885.77	52314.9	536200.67
BON SECOURS	47,405.2	13,018.9	20,309.8	0.0	0.0	80,733.9	7,272.2	598.1	88,604.1	7,870.3	8.88%	143,351.1	12,733.2	1.271352	$10,015.5	0	-4646.8	83957.3	23794	107751.3
FRANKLIN SQUARE	197,079.3	32,436.1	58,414.0	2,387.3	8,104.3	298,421.0	19,088.8	2,992.7	320,502.6	22,081.5	6.89%	439,816.3	30,301.8	1.117684	$27,111.2	-1934.5	-54387	264181.1	30595.1	294776.16
WASHINGTON ADV.	139,947.0	23,395.4	43,676.4	2,743.1	0.0	209,761.9	8,913.7	2,729.3	221,404.9	11,643.0	5.26%	274,957.8	14,459.2	1.139653	$12,687.4	0	-1881.6	219523.3	34989.5	254512.8
GARRETT CO.	17,322.2	3,820.3	5,045.8	0.0	0.0	26,188.4	2,152.0	675.4	29,015.8	2,827.4	9.74%	43,146.5	4,204.3	1.129115	$3,723.6	0	-664.9	28350.9	4403.5	32754.402
MONTGOMERY GEN.	69,297.7	14,989.4	22,359.0	0.0	0.0	106,646.1	7,641.2	1,388.8	115,676.1	9,030.0	7.81%	158,377.0	12,363.4	1.110479	$11,133.4	0	-2101.1	113575.1	14234.9	127809.98
PENINSULA REG.	203,236.1	32,988.7	39,403.7	213.0	0.0	275,841.5	21,974.5	6,370.5	304,186.5	28,345.0	9.32%	414,192.9	38,595.7	1.104771	$34,935.4	0	2284.576	306471.08	36559.3	343030.38
SUBURBAN	124,981.1	27,226.6	26,954.0	174.6	83.5	179,419.8	15,585.3	3,201.4	198,206.5	18,786.7	9.48%	251,910.2	23,876.9	1.089090	$21,923.7	-370.5	-4740.47	193095.56	18223.4	211318.96
ANNE ARUNDEL GEN.	224,164.8	35,443.4	41,735.0	0.0	0.0	301,343.2	33,270.6	4,475.2	339,089.0	37,745.8	11.13%	447,964.1	49,865.3	1.081495	$46,107.7	-1159	-26341.8	311588.2	28929.2	340517.42
UNION MEM.	193,602.4	31,076.4	50,006.0	3,647.5	10,144.9	288,477.1	19,761.1	3,668.6	311,906.8	23,429.7	7.51%	398,501.1	29,934.5	1.102807	$27,143.9	-2020	878.7	310765.6	32597.4	343362.98
WESTERN MARYLAND	140,948.1	27,990.3	35,566.8	0.0	0.0	204,505.2	23,755.2	4,567.1	232,827.5	28,322.3	12.16%	290,879.6	35,384.1	1.093205	$32,367.3	0	-7863.482	224964.01	23922.1	248886.11
ST. MARY'S	56,863.6	8,687.2	19,121.1	0.0	0.0	84,671.9	7,301.3	1,017.2	92,990.3	8,318.5	8.95%	135,739.4	12,142.6	1.112241	$10,917.3	0	110.9	93101.2	10056.3	103157.51
BAYVIEW	264,373.7	44,213.4	63,990.6	2,397.1	18,324.0	393,298.8	31,233.9	3,192.7	427,725.3	34,426.6	8.05%	552,278.1	44,451.5	1.133618	$39,212.1	-1424.6	-771.386	425529.35	58637.3	484166.65
CHESTER RIVER	28,212.7	7,268.8	10,431.3	0.0	0.0	45,912.8	1,946.2	1,222.3	49,081.3	3,168.5	6.46%	63,037.9	4,069.5	1.131146	$3,597.7	-510.5	1327.1	49897.9	7914.4	57812.331
UNION OF CECIL	59,504.4	11,154.8	19,153.3	0.0	0.0	89,812.5	10,698.5	1,985.9	102,496.9	12,684.4	12.38%	138,746.9	17,170.5	1.122508	$15,296.5	0	-8517	93979.9	14734.3	108714.2
CARROLL CO. GEN.	94,308.5	17,302.0	31,837.9	0.0	0.0	143,448.4	23,191.1	1,310.7	167,950.2	24,501.8	14.59%	217,799.3	31,774.2	1.093501	$29,057.3	0	-946.323	167003.91	15394.1	182398.01
HARBOR HOSP.	90,679.1	21,120.4	28,509.1	1,056.8	4,138.2	145,503.6	9,376.3	1,806.4	156,686.3	11,182.7	7.14%	208,871.8	14,907.2	1.133401	$13,152.6	0	-3710.4	152975.9	20760.8	173736.72
CIVISTA	52,931.2	10,746.3	19,433.7	0.0	0.0	83,111.3	8,184.6	1,673.2	92,969.1	9,857.8	10.60%	119,423.5	12,662.8	1.114876	$11,358.1	0	-26.54614	92942.535	10871.84	103814.38
MEM. EASTON	74,428.1	13,736.9	30,809.9	0.0	0.0	118,974.8	10,980.0	3,144.2	133,099.0	14,124.2	10.61%	177,113.0	18,794.9	1.100283	$17,081.9	0	-4095.3	129003.7	12658.2	141661.9
MARYLAND GEN.	73,955.5	22,031.0	25,491.2	0.0	3,730.3	125,207.9	9,324.4	1,765.7	136,298.0	11,090.1	8.14%	181,521.3	14,769.8	1.191314	$12,397.9	0	437	136735	24509.2	161244.23
CALVERT MEMORIAL	56,013.8	13,491.8	17,435.9	0.0	0.0	86,941.6	9,707.2	1,130.2	97,779.0	10,837.4	11.08%	131,798.1	14,607.9	1.100873	$13,269.4	0	-283	97495.9	10302.9	107798.84
NORTHWEST	94,530.8	21,500.2	26,170.3	2,909.5	0.0	145,110.8	14,522.4	1,717.9	161,351.2	16,240.3	10.07%	236,963.8	23,850.9	1.123389	$21,231.2	0	128.1	161479.25	23534.1	185013.35
BALTIMORE/WASHINGTON	170,900.6	27,556.5	48,070.8	0.0	326.6	246,854.5	25,082.3	3,538.0	275,474.8	28,620.3	10.39%	368,918.1	38,328.5	1.117423	$34,300.8	0	-329.4	275145.4	35585	310730.44
G.B.M.C.	206,103.3	32,622.4	60,727.8	0.0	5,207.0	304,660.6	26,958.8	3,201.0	334,820.3	30,159.8	9.01%	420,167.7	37,847.7	1.074480	$35,224.2	0	-6248.5	328571.9	23912	352483.85
MCCREADY	6,123.5	1,513.9	2,613.2	82.5	0.0	10,333.1	786.4	276.5	11,396.1	1,062.9	9.33%	19,403.8	1,809.8	1.150354	$1,573.2	0	-132.8	11263.3	2279.3	13542.6
HOWARD CO. GEN.	128,335.5	23,771.9	28,075.9	408.2	0.0	180,591.5	18,827.4	2,058.6	201,477.4	20,886.0	10.37%	259,985.0	26,951.1	1.102116	$24,453.9	0	1345.503	202822.91	21196.2	224019.11
UPPER CHESAPEAKE	109,181.7	18,042.5	26,531.5	0.0	0.0	153,755.6	13,655.6	1,067.7	168,478.9	14,723.3	8.74%	243,410.6	21,271.5	1.103346	$19,279.1	0	1013.3	169492	19804.4	189296.4
DR'S COMMUNITY HOSP.	105,795.8	17,745.4	24,271.5	577.5	0.0	148,390.1	13,717.4	1,808.1	163,915.6	15,525.5	9.47%	224,332.1	21,247.9	1.130785	$18,790.4	0	-1452.4	162463.2	22455.7	184918.91
SOUTHERN MD.	101,009.6	13,150.8	42,601.6	0.0	0.0	156,762.5	14,270.2	1,896.2	172,928.5	16,166.4	9.35%	252,552.5	23,610.1	1.126070	$20,966.8	0	4776.2	177705	25711.5	203416.5
LAUREL REGIONAL	54,198.5	11,201.5	15,101.9	0.0	0.0	80,501.9	4,405.5	407.1	85,314.5	4,812.6	5.64%	109,899.8	6,199.5	1.161162	$5,339.0	0	140.225	85454.73	16335.1	101789.83
FORT WASHINGTON	22,346.3	3,897.0	7,278.7	0.0	0.0	33,522.0	2,345.2	351.3	36,218.6	2,696.5	7.45%	49,466.3	3,682.8	1.168069	$3,152.9	0	-447.4	35771.2	7269	43040.26
ATLANTIC GENERAL	38,923.9	6,426.6	13,197.4	0.0	0.0	58,547.9	3,325.9	1,573.4	63,447.2	4,899.3	7.72%	89,189.2	6,887.1	1.105368	$6,230.6	0	-1348.1	62099.2	7588.9	69688.097
KERNANS	52,414.1	11,135.4	15,067.6	772.3	3,520.4	82,909.8	3,348.8	577.5	86,836.1	3,926.3	4.52%	118,890.1	5,375.6	1.120780	$4,796.3	0	-846.4	85989.7	11671.7	97661.439
GOOD SAMARITAN	143,487.3	23,330.0	41,470.3	260.4	4,513.0	213,061.0	15,455.3	2,134.1	230,650.4	17,589.4	7.63%	300,290.3	22,900.1	1.104519	$20,733.1	0	-3911.6	226738.8	26295.5	253034.35
SHADY GROVE	165,216.9	31,314.3	48,616.0	2,361.1	0.0	247,508.3	20,088.1	2,276.8	269,873.3	22,364.9	8.29%	349,821.1	28,990.3	1.111827	$26,074.5	0	-2971.2	266902.1	30016.28	296918.41
SHOCK TRAUMA	67104.4	4946.3	53554.9	0	8471.9	134077.5	4373.2	409.3	138860	4,782.5	3.44%	220,237.4	7,585.2	1.387383	$5,467.3	0	0	138860	51678	190537.99
CANCER CENTER	28,933.1	4,194.9	22,026.5	0.0	2,745.1	57,899.6	2,215.6	416.4	60,531.6	2,632.0	4.35%	61,946.3	2,693.5	1.205810	$2,233.8	0	1069.7	61601.3	12089.7	73690.998
Total	6,602,202.5	1,176,506.7	1,771,993.2	62,275.2	223,550.9	9,836,529.1	819,731.4	121,702.6	10,777,963.0	941,434.0	8.73%	14,378,578.9	1,257,496.7	1.118137	1,128,283.1	-40,190.2	-170,065.1	10,567,707.9	1,320,209.0	11,887,916.9
Percent to Tot	61.26%	10.92%	16.44%	0.58%	2.07%	91.27%	7.61%	1.13%												
						9,836,528.6			10,777,963.1									10,567,707.6	1.1249	11,887,916.9

Maryland
Hospital Association

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January 5, 2012

The Honorable Edward J. Kasemeyer
Chair, Senate Budget and Taxation Committee
3 West Miller Senate Building
Annapolis, MD 21401-1991

The Honorable Norman H. Conway
Chair, House Appropriations Committee
121 House Office Building
Annapolis, MD 21401-1991

The Honorable James N. Robey
Chair, Health and Human Services Subcommittee
3 West Miller Senate Building
Annapolis, MD 21401-1991

The Honorable Mary-Dulany James
Chair, Health and Human Services Subcommittee
3 West Miller Senate Building
Annapolis, MD 21401-1991

RE: MHA Comments on the 2011 Joint Chairmen's Report, Page 84, M00R01.02 – Health Services Cost Review Commission, Inclusion of Capital Replacement Costs in Hospital Rates

Dear Chairs Kasemeyer, Conway, Robey, and James:

On behalf of the 66 members of the Maryland Hospital Association (MHA), we are writing to share our views on the Health Services Cost Review Commission (HSCRC) report on the feasibility of including capital replacement costs in hospital rates. Unfortunately, the report describes historical HSCRC capital funding policies without recognizing how more recent changes in hospital reimbursement policies are affecting hospitals' ability to fund capital costs, especially the costs of replacing aging facilities and investing in infrastructure needed to support health information technology. In addition, the report inaccurately concludes that hospital rates include substantial funding for capital costs, even though HSCRC policies do not allocate dedicated annual funding for specific costs other than uncompensated care.

Traditionally, growth in the utilization of hospital services has been the most widely used mechanism to fund hospitals' capital needs in Maryland and the U.S. Hospitals with strong volume growth and disciplined expense control were able to build reserves and fund capital projects without additional rate increases aimed specifically at capital projects. Two payment arrangements--Total Patient Revenue and Admission-Readmission Revenue—that are now in place at 41 of Maryland's 46 acute care hospitals provide strong incentives to reduce volume growth. Maryland's hospital admissions declined more than 1 percent in fiscal year 2010, more than 4 percent in fiscal year 2011, and are continuing to decline in fiscal year 2012. The transition toward health care payment policy that rewards value and quality, not volume, moves Maryland in the right direction. But the "Catch-22" is that, without volume growth, new mechanisms must be found to fund capital replacement and information technology needs.

The HSCRC report's conclusion that there is substantial funding for capital in hospital rates is misleading. In 2012 and 2013, hospital balance sheets will be hit hard by new fixed costs. These include expenses for recently completed capital projects and those that are not yet open, and for the enormous health information technology costs required to integrate care delivery

- more -

across provider settings and enable robust coordination of care, including patient centered medical homes. For example, expenses for information technology are expected to increase by nearly 1 billion over the next two years, and, in the first quarter of fiscal year 2012, compared with the first quarter of fiscal year 2011, capital costs increased nearly 12 percent. Total revenues, meanwhile, grew by only 5 percent.

HSCRC asserts that, because hospitals' capital costs represent 8.7 percent of total expenses, 8.7 percent of rates were added to fund capital costs. However, the amount of funding for capital in hospitals' rates varies according to each hospital's circumstances, such as whether the hospital has recently initiated a capital project, and whether the hospital was able to qualify for a rate increase to help fund a portion of the new debt. Because HSCRC funded only a portion of the capital costs at a handful of hospitals, it is not possible to extrapolate a specific amount designated for capital in rates.

Hospitals have received varying amounts of rate support over recent years to help fund capital costs. As health care reimbursement and HSCRC payment policies increasingly provide incentives that reward value for the health care dollar, and discourage growth in the utilization of health care services, MHA agrees with HSCRC that capital planning and funding policies need to be revised. We look forward to working with HSCRC staff and other stakeholders to ensure that those policies allow hospitals the support they need make sure Marylanders have the modern health care facilities and technologies they deserve.

If you have any questions regarding MHA's comments or recommendations, please contact me at (410) 379-6200.

Sincerely,

Michael B. Robbins

Michael B. Robbins,
Senior Vice President, Financial Policy

cc: Joseph R. Antos, Ph.D., Commissioner, HSCRC
George H. Bone, M.D., Commissioner, HSCRC
John M. Colmers, Chairman, HSCRC
Jack C. Keane, Commissioner, HSCRC
Bernadette C. Loftus, M.D., Commissioner, HSCRC
Thomas R. Mullen, Commissioner, HSCRC
Stephen Ports, Principal Deputy Director, Policy & Operations, HSCRC
Patrick Redmon, Ph.D., Executive Director, HSCRC
Herbert S. Wong, Ph.D., Vice Chairman, HSCRC

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

John M. Colmers
Chairman

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Executive Director

Stephen Ports
Principal Deputy Director
Policy and Operations

Gerard J. Schmith
Deputy Director
Hospital Rate Setting

Mary Beth Pohl
Deputy Director
Research and Methodology

TO: Commissioners

FROM: Legal Department

DATE: January 25, 2012

RE: Hearing and Meeting Schedule

Public Session:

March 7, 2012 1:00 p.m., 4160 Patterson Avenue, HSCRC Conference Room

April 11, 2012 Time to be determined, 4160 Patterson Avenue, HSCRC Conference Room

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

The Agenda for the Executive and Public Sessions will be available for your review on the Thursday before the Commission meeting on the Commission's website.
www.hscrc.state.md.us/commissionMeetingSchedule2012.cfm

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