HEALTH SERVICES COST REVIEW COMMISSION
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Post-meeting Documents
from the
499th MEETING OF THE HEALTH SERVICES COST REVIEW COMMISSION
July 10, 2013

EXECUTIVE SESSION
12:00 p.m.

1. **Comfort Order – Johns Hopkins Health System**
2. **Waiver Update**
3. **Personnel Matters**

PUBLIC SESSION
1:00 p.m.

1. **Review of the Minutes from the Executive Session and Public Meeting Minutes from June 5, 2013 - Amended and Approved at September 4, 2013 Commission Meeting**

2. **Executive Director's Report**

3. **Docket Status – Cases Closed**

   2209A – University of Maryland Center
   2011A – Johns Hopkins Health System

4. **Docket Status – Cases Open**

   2208R – Southern Maryland Hospital Center
   2210A – Johns Hopkins Health System - Approved
   2212A – Johns Hopkins Health System - Approved
   2213A – University of Maryland Medical Center - Approved as Revised
   2214A – University of Maryland Medical Center - Approved
   2215A – Upper Chesapeake Medical Center
   2216A – Johns Hopkins Health System - Approved

5. **Final Recommendation on FY 2014 Update Factor for Psychiatric and Specialty Hospitals**

6. **Update on Matching of Chesapeake Regional Information System for Our Patients (CRISP) and HSCRC Inpatient data**

7. **Draft Recommendation for the Expansion of Required Health Information Exchange Data to Support Population-based Methodologies**

8. **Report on Final Year of Funding through HSCRC for CRISP**

9. **Annual Community Benefit Report + Individual Narratives and Reports on Website**

10. **Legal Report**

11. **Hearing and Meeting Schedule**

AMENDED
MINUTES OF THE
498th MEETING OF THE
HEALTH SERVICES COST REVIEW COMMISSION

June 5, 2013

Chairman John Colmers called the meeting to order at 1:02 p.m. Commissioners George H. Bone, M.D., Stephen F. Jencks, M.D., M.P.H., Jack C. Keane, Thomas R. Mullen, Bernadette C. Loftus, M.D., and Herbert S. Wong, Ph.D. were also present.

REPORT OF THE MAY 29th AND JUNE 5th 2013 EXECUTIVE SESSIONS

Dennis Phelps, Associate Director-Audit & Compliance, summarized the minutes of the May 29 and June 5, 2013 Executive Sessions.

ITEM I
REVIEW OF THE MINUTES OF THE MAY 1, 2013 EXECUTIVE SESSION AND PUBLIC MEETING

The Commission voted unanimously to approve the minutes of the May 1, 2013 Executive Session and Public Meeting.

INTRODUCTION OF DONNA KINZER AS ACTING EXECUTIVE DIRECTOR

Chairman Colmers announced the appointment of Donna Kinzer as the Acting Executive Director of the HSCRC for a period not to exceed six months. The Chairman stated that Ms. Kinzer will lead the Commission staff in much of the work of the Commission in particular the activities associated with our waiver demonstration application and, we hope, its successful implementation.

The Chairman noted Ms. Kinzer has long experience with the Maryland rate setting system and has worked with many of the stakeholders on all sides of issues before the Commission.

Ms. Kinzer stated that she was honored to serve the citizens of Maryland as Executive Director of the Commission. Ms. Kinzer expressed her appreciation for the opportunity to work with the Commission's staff when there was so much important work to do.

ITEM II
EXECUTIVE DIRECTOR'S REPORT

Ms. Kinzer reported that Monitoring Maryland Performance (MMP) indicated that the rate of growth in charge per case (CPC) increased by 0.71% for the month of April 2013 from the month of April 2012. For the twelve months ending April 2013 CPC increased 0.76% from the twelve months ending April 2012; inpatient revenue decreased 2.72%; the number of inpatient cases declined by 3.45%; outpatient revenue increased 12.19%; total gross revenue increased 2.71%.

Ms. Kinzer stated that for the fiscal year-to-date ending April 2013, average operating profit for acute care hospitals was 0.68%. Ms. Kinzer noted that according to hospital representatives, an important factor to consider when looking at these operating profit numbers is that they may be overstated because they include funds from the Centers for Medicare and Medicaid Services' (CMS) Meaningful Use program.

Ms. Kinzer noted that now that the State's Model Demonstration proposal has been submitted to the federal government discussions with the Centers for Medicare and Medicaid Innovation (CMMI) continue.

Ms. Kinzer announced that Commission staff is developing a series of Work Groups to discuss key issues in payment and delivery reform, including specific issues posed in the Application. A list of Work Groups, timelines, and structure will be distributed in the near future.

Ms. Kinzer stated that Commission staff will report on CRISP's progress in linking claims across hospitals and present a recommendation for CRISP funding at the July public meeting.

ITEM IIIV
DOCKET STATUS CASES CLOSED

2204N – St. Agnes Hospital
2205N – MedStar Harbor Hospital
2206A – Johns Hopkins Health System
2207A – Johns Hopkins Health System

ITEM IV
DOCKET STATUS CASES OPEN
University of Maryland Medical Center – 2209A

University of Maryland Medical Center filed an application with the HSCRC on May 28, 2013 for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The Hospital requested approval from the HSCRC to continue to participate in a global rate arrangement for liver and blood and bone marrow transplants for a period of one year with Cigna Health Corporation beginning July 1, 2013.

The staff recommended that the Commission approve the Hospital's application for an alternative method of rate determination for liver and blood and bone marrow transplant services, for a one year period commencing July 1, 2013. Staff also recommended that the approval be contingent upon the execution of the standard Memorandum of Understanding.

The Commission voted unanimously to approve staff's recommendation.

Johns Hopkins Health System – 2011A

Johns Hopkins Health System filed an application with the HSCRC on May 28, 2013 on behalf of Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System requested approval from the HSCRC to continue to participate in a global rate arrangement for solid organ and bone marrow transplant services with MultiPlan, Inc. for a period of one year beginning August 1, 2013.

The staff recommended that the Commission approve the Hospitals' application for an alternative method of rate determination for solid organ and bone marrow transplant services, for a one year period commencing August 1, 2013. Staff also recommended that the approval be contingent upon 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
FINAL RECOMMENDATIONS FOR THE FY 2014 UPDATE FACTOR

Steve Ports, Principal Deputy Director, presented the background and the process utilized to develop staff's final recommendations for the FY 2014 update factor; Sule Calikogul, Ph.D., Associate Director for Performance Measurement, discussed the status of the Medicare waiver cushion; and Jerry Schmith, Deputy Director Hospital Rate Setting, described the financial condition of the hospital industry and presented a comparison of the Update Factor proposals of the Maryland Hospital Association, CareFirst and United Healthcare, and staff.

Mr. Schmith then presented staff's recommendations for the FY 2014 Update Factor (see "Update Factor Recommendation for FY 2014" on the HSCRC website. The recommendation included: 1) applying an update factor of 1.65% to both inpatient and outpatient rates of all hospitals for which the HSCRC sets rates for a stub period July 1, 2013 through December 31, 2013,and revisiting the update factor for the period January 1, 2014 through June 30, 2014 taking into consideration, among other things, the status of the model design application, and related implications (such as aggregate spending), factor cost, the waiver cushion, and hospitals' financial condition; 2) applying all adjustments and assessments for FY 2014 on January 1, 2014

in a manner that would have the full annual impact for the fiscal year; 3)applying the Shared Saving adjustment on January 1, 2014 in a manner that would achieve the full savings from the program in FY 2014; 4) permanently eliminating the One Day Stay Case Mix Adjustment; 5) continuing the reallocation of overhead to increase inpatient revenue for FY 2014; and 6) not applying a Reasonableness of Charges scaling for FY 2014.

Mr. Schmith stated that staff believes that it has taken a reasoned and balanced approach in its Update Factor recommendation recognizing the financial challenges of the hospital industry on the one hand, while maintaining the waiver cushion until more is known about the alternative waiver model.

Bruce Edwards, Senior Vice President for Networks of CareFirst of Maryland, presented CareFirst's comments on staff's recommendation (see "CareFirst letter of June 5, 2013" on the HSCRC website). Mr. Edwards stated that CareFirst agreed with staff recommendations #2 through #6. However, CareFirst suggested that, at a minimum, the waiver cushion be in the range of 3.5%, and that the Commission adopt an Update factor of 1.35%.

Gary Simmons, Regional Vice President of United HealthCare, expressed support for CareFirst's recommendations.

A panel consisting of: Carmela Coyle, President of the Maryland Hospital Association (MHA), Robert A. Chrencik, President and CEO of the University of Maryland Medical Health System, Stuart Erdman, Senior Director of Finance & Assistant Treasurer of the Johns Hopkins Health System, Raymond A. Grahe, Vice President, Finance of Meritus Health, and Michael Robbins, Senior Vice President of MHA, presented comments on staff's final recommendation.

Ms. Coyle pointed out that hospital operating margins have continued to decline as the result of four years of update factors that were less than factor inflation. Ms. Coyle stated that the Commission must balance waiver retention and the financial condition of Maryland hospitals in its update factor deliberations. Ms. Coyle also urged the Commission to take into consideration the potential favorable adjustments to the waiver test.

Mr. Chrencik discussed in detail the financial condition of hospital industry. Mr. Chrencik stated that the update factors recommended by staff and the payers included a productivity adjustment that was equal to the market basket's factor inflation for wages and benefits and no funding for new technology. Adoption of staff's recommended update factor would lead to decreases in hospital operating margins. According to Mr. Chrencik, continued decreases in hospital operating margins will eventually result in downgrades by bond rating agencies, which may deny Maryland hospitals access to the capitals market. Mr. Chrencik noted that the adoption of MHA's suggested update factor would not increase operating margins; however, it would give hospitals the opportunity to maintain the status quo.

Mr. Grahe asserted that because Medicaid assessments have put pressure on the waiver test hospitals have, in fact, paid for the assessments through lower updates. Mr. Grahe stated that

participating in the Affordable Care Act's Shared Savings Program is appropriate; however, in order to do so hospitals need a full update factor.

Mr. Erdman stated that MHA's proposed update factor is affordable. Mr. Erdman pointed out that hospitals depend on people and capital. Low updates and declining operating profits result in a slowdown in spending on capital projects and equipment, and reduce hospitals' ability to provide unregulated community services, all of which ultimately affect patients.

Mr. Robbins addressed the status of the waiver cushion. Mr. Robbins requested that the Commission take into consideration in its deliberations on the update factor the potential adjustments to the national waiver test data. According to Mr. Robbins, the correction of two actuarial errors could result in an increase in the June 2014 waiver cushion by 3.69%, from an estimated 1.85% to 5.54%.

Steven S. Sharfstein, M.D., President and CEO of the Sheppard Pratt Health System, requested that the Commission adopt a separate update factor for Maryland's private psychiatric hospitals. Dr. Sharfstein noted that since the private psychiatric hospitals are not under the Medicare waiver and do not affect the waiver cushion, they should receive an update factor of 2.23%. Dr. Sharfstein pointed out that the update factor was calculated utilizing a methodology consistent with that utilized to calculate last year's update factor for private psychiatric hospitals.

Commissioner Wong made a motion to accept staff's recommendation.

Commissioner Loftus seconded the motion.

Commissioner Jencks expressed support for Dr. Wong's motion with the caveat that the deferral of the Shared Savings adjustment be made July 1, 2013. According to Dr. Jencks, the pressure of living with limited resources is the only way to improve productivity in an environment where cost competition has been essentially removed. In addition, Dr. Jencks expressed concern about the reliability of the process used to forecast the waiver cushion. Dr. Jencks speculated that failure of the waiver test might lead to a phasing out of the waiver.

Commissioner Keane agreed with Dr. Jencks' contention that absent financial pressure, we do not achieve productivity. In addition, Commissioner Keane stated that he was not persuaded by the hospital industry's argument about their financial condition since Maryland hospitals' current total margins are in the same range as they have been for the last five years. Commissioner Keane asserted that historically not-for-profit hospitals throughout the country have lived quite happily with no operating margins. According to Commissioner Keane, large operating margins put the hospital industry at risk for capital investment and capital spending that is not generally in the public interest. Commissioner Keane stated that staff's recommendation is reasonable and expressed support for Dr. Wong's motion.

Commissioner Mullen stated that it is clear that Maryland's hospital industry is hurting financially. Commissioner Mullen noted that non-operating activities largely have to do with

things that are out of the control of hospitals. Non-operating profits are up this year because of the rise of the stock market and low interest rates; next year, who knows what will happen. Commissioner Mullen noted that most people believe that operations and operating profits are the way to evaluate the efficiency of hospitals. The rating agencies have set the threshold for operating margins for the category of borrowers that includes most Maryland hospitals at 3% plus and the average Maryland hospital is below that threshold. Commissioner Mullen pointed out that the Maryland hospital industry has operating margins that produce a bond rating of slightly above investment grade, and the Commission should understand this when it makes its decision on an update factor. Commissioner Mullen stated that the waiver cushion is a major consideration, and we must be cautious. However, in the last two years, we have seen productivity adjustments of close to 2.5% that resulted in a drop in operating profits of nearly 1.8%. Commissioner Mullen expressed concern that if the update factor adopted by the Commission is too low, we will see a further decline in operating margins. Commissioner Mullin stated that he could support staff's recommendation with the caveat that it is on the borderline of acceptability and with the understanding that in January everything should be reassessed including where we are with the waiver process and hospital profitability.

A friendly amendment to carve-out Specialty Hospitals from staff's update factor recommendation and to add that it apply only to acute general hospitals was made and seconded.

The Commission voted unanimously to approve staff's amended recommendation.

ITEM VI
FINAL RECOMMENDATIONS ON MODIFICATIONS TO THE OUTLIER TRIM METHODOLOGY

Ms. Pohl summarized staff's Final Recommendation on Modifications to the Outlier Methodology (see "Final Recommendation on Modifications to the Outlier Methodology" on the HSCRC website). The recommendations were: 1) to trim cases and revenue associated with low resource cases; and 2) to utilize case mix data with a proportional adjustment to financial data to support the application of the outlier methodology in rate setting activities.

The Commission voted unanimously to approve staff's recommendation.

ITEM VII
FINAL RECOMMENDATION ON FY 2014 NURSE SUPPORT PROGRAM II COMPETITIVE INSTITUTIONAL GRANTS

Ms. Pohl presented staff's final recommendation for the Nurse Support Program II FY 2014 Competitive Institutional Grants (see "Final Recommendation: HEALTH SERVICES COST REVIEW COMMISSION – Nurse Support Program II – FY 2014 COMPETITIVE INSTITUTIONAL GRANTS" on the HSCRC website). Staff recommended that the fifteen

Competitive Institutional Grants recommended by the NSP II Grant Review Panel be considered by the Commission for FY 2014.

The Commission voted unanimously to approve staff's recommendation.

ITEM VIII
REPORT ON CHANGES TO THE QUALITY BASED REIMBURSEMENT PROGRAM FOR FY 2015

Dianne Feeney, Associate Director-Quality Initiative, summarized staff's Report Updating the Commission on Changes to the Quality Based Reimbursement (QBR) Program for FY 2015 (see "Report Updating the Commission on Changes to the Quality Based Reimbursement (QBR) Program for FY 2015" the HSCRC website).

Mr. Robbins thanked the Commission's staff for accepting the mortality measure; however, he expressed concern that the staff had not adopted an efficiency measurement tool for FY 2015.

ITEM IX
HEARING AND MEETING SCHEDULE

July 10, 2013	Time to be determined, 4160 Patterson Avenue, HSCRC Conference Room
August 7, 2013	Time to be determined, 4160 Patterson Avenue, HSCRC Conference Room

There being no further business, the meeting was adjourned at 3:22 p.m.

EXECUTIVE DIRECTOR'S REPORT
JULY 10, 2013

Monitoring Maryland Performance

For Year Ending May 2013

- Charge per Case increased 1.88%
    - For YTD ending May 2013 versus the same time period in 2012, CPC increased 1.69%
- Cases (admissions + new born) decreased 3.68%
- Inpatient revenue decreased 1.87%
- Outpatient revenue increased 10.91%
- Total gross revenue increased 2.85%
    - For YTD ending May 2013 versus the same period in 2012, total gross revenue increased 2.64%.

Financial Condition

Data are available for profits for the eight months through May 2013 compared to the eight months through May 2012. For year-to-date ending May 2013, average operating profits for all acute care hospitals was 0.72 percent. The total profit margin for this period is 3.61%. The median hospital had an operating profit of 1.26 percent, with a distribution as follows:

- 25^{th} percentile at -1.07 percent
- 75^{th} percentile at 4.84 percent

According to hospital representatives, an important factor to consider in these numbers is that Meaningful Use funds are included in these numbers as operating revenue and may overstate the usual operating revenue.

The margins are highly influenced by potential transitional issues and losses at University of Maryland St. Joseph's Medical Center (UMSJMC). When excluding UMSJMC, the financial results of the industry through May 2013 are as follows:

- Operating Profit Margin: 1.24%
- Total Profit Margin: 4.20%
- Median Operating Margin: 1.51%
- Operating Margin 25^{th} Percentile: -0.65%
- Operating Margin 75^{th} Percentile: 4.89%

Progress on Demonstration Request

The Governor submitted the State's Model Demonstration Proposal to the Federal government on March 26, 2013. Discussions continue with CMMI around details of the proposal.

Work Groups for Payment and Delivery Reform--Progress

Commission Staff are continuing with development of Work Groups to discuss the key issues in implementing new population based and patient centered payment models, including specific issues posed in the Proposal. The Commission will soon release a draft workgroup plan and we will begin the process of seeking chairs and people interested in serving on workgroups.

Rate Orders and Upcoming Rate Activities

After the update factor approval last month, staff was able to issue the rate orders for July 1, 2013. These rate orders were simplified, as planned, to allow for quick turnaround. There will be another rate order settling up the 2013 fiscal year in January and updating for a series of case mix changes. This promises to be a technically challenging process, with updates including:

- Numerous changes to case mix data
    - Incorporate 1 day stays
    - Outlier modification—low outliers
    - APR Grouper 30—the most significant grouper change in many years
    - ARR (CPE) weights modified to incorporate 1 day stays
    - Issues with ER Observation to resolve due to incorporating 1 day stays
        - Impact on ARR gains
        - Rate capacity "profit" generation if trend is reversed
        - Impact on case mix governor
- Multiple settlement periods

Promotion

We are pleased to announce the promotion of Sule Calikoglu, PhD to fill the position of Deputy Director of Research and Methodology.

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

AS OF JULY 3, 2013

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
2208R	Southern Maryland Hospital Center	5/6/2013	8/7/2013	10/3/2013	PEDS	CK	OPEN
2210A	Johns Hopkins Health System	5/28/2013	N/A	N/A	ARM	DNP	OPEN
2212A	Johns Hopkins Health System	5/30/2013	N/A	N/A	ARM	DNP	OPEN
2213A	University of Maryland Medical Center	6/11/2013	N/A	N/A	ARM	DNP	OPEN
2214A	University of Maryland Medical Center	6/11/2013	N/A	N/A	ARM	DNP	OPEN
2215A	Upper Chesapeake Medical Center	6/14/2013	8/7/2013	11/12/2013	RAT	CK	OPEN
2216A	Johns Hopkins Health System	6/18/2013	N/A	N/A	ARM	DNP	OPEN

NONE

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:**	**2013**
SYSTEM	*	**FOLIO:**	**2020**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2210A**

Staff Recommendation

Approved

July 10, 2013

I. INTRODUCTION

The Johns Hopkins Health System ("System") filed an application with the HSCRC on May 22, 2013 on behalf of Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center (the Hospitals) for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System requests approval from the HSCRC for participation in a global rate arrangement for solid organ and bone marrow transplant services with 6 Degrees Health, Inc. for a period of one year beginning July 1, 2013.

II. OVERVIEW OF APPLICATION

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

III. FEE DEVELOPMENT

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

IV. IDENTIFICATION AND ASSESSMENT OF RISK

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

V. STAFF EVALUATION

Since the format utilized to calculate the case rate, i.e., historical data for like cases, has

been utilized as the basis for other successful transplant arrangements in which the Hospitals are currently participating, staff believes that the Hospitals can achieve a favorable experience under this arrangement.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for solid organ and bone marrow transplant services for a one year period commencing July 1, 2013. 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:**	**2013**
SYSTEM	*	**FOLIO:**	**2022**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2212A**

Staff Recommendation

Approved

July 10, 2013

I. INTRODUCTION

On May 30, 2013, the Johns Hopkins Health System ("System") filed a renewal application on behalf of its member hospitals Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, and Howard County General Hospital (the "Hospitals") requesting approval from the HSCRC to continue to participate in a renegotiated global rate arrangement for cardiovascular procedures with the Coventry Health Care of Delaware, Inc. for international patients only. The Hospitals request that the Commission approve the arrangement for one year effective July 1, 2013.

II. OVERVIEW OF APPLICATION

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

III. FEE DEVELOPMENT

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

IV. IDENTIFICATION AND ASSESSMENT OF RISK

The Hospitals will continue to submit bills to JHHC for all contracted and covered services. JHHC is responsible for billing the payer, collecting payment, 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 experience under this arrangement was favorable for the last year. Staff believes that the Hospitals can continue to achieve favorable performance under this arrangement.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for cardiovascular services for one year beginning July 1, 2013. The Hospitals must file a renewal application annually for continued participation, with approval contingent upon a favorable evaluation of performance.

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

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**
DETERMINATION	*	**COMMISSION**
UNIVERSITY OF MARYLAND	*	**DOCKET: 2013**
MEDICAL CENTER *		**FOLIO: 2023**
BALTIMORE, MARYLAND	*	**PROCEEDING: 2213A**

REVISED

Staff Recommendation

Approved

July 10, 2013

I. INTRODUCTION

University of Maryland Medical Center ("Hospital") filed an application with the HSCRC on June 11, 2013 for an alternative method of rate determination pursuant to COMAR 10.37.10.06. The Hospital requests approval from the HSCRC for continued participation in global rates for solid organ transplant and blood and bone marrow transplants for one year with Aetna Health, Inc. beginning August 1, 2013.

II. OVERVIEW OF THE APPLICATION

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

III. FEE DEVELOPMENT

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

IV. IDENTIFICATION AND ASSESSMENT OF RISK

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

V. STAFF EVALUATION

Staff reviewed the experience under this arrangement and found it to be favorable. Staff believes that the Hospital can continue to achieve favorable performance under this arrangement.

VI. STAFF RECOMMENDATION

Based on the Hospital's favorable performance, staff recommends that the Commission approve the Hospital's application for an alternative method of rate determination for solid organ transplant, gamma knife, and blood and bone marrow transplant services, for a one year period beginning August 1, 2013. The Hospital will need to file a renewal application to be considered for continued participation.

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

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION	*	**COMMISSION**	
UNIVERSITY OF MARYLAND	*	**DOCKET:**	**2013**
MEDICAL CENTER	*	**FOLIO:**	**2024**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2214A**

Staff Recommendation

Approved

July 10, 2013

I. INTRODUCTION

The University of Maryland Medical Center ("Hospital") filed an application with the HSCRC on June 11, 2013 requesting approval to continue its participation in a global rate arrangement with Maryland Physicians Care ("MPC") for solid organ and blood and bone marrow transplant services for a period of one year beginning August 23, 2013.

II. OVERVIEW OF APPLICATION

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

III. FEE DEVELOPMENT

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

IV. IDENTIFICATION AND ASSESSMENT OF RISK

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

V. STAFF EVALUATION

Staff found that the actual experience under the arrangement for the last year has been favorable. Staff believes that the Hospital can continue to achieve favorable performance under this arrangement.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospital's application for an alternative method of rate determination for solid organ and blood and bone marrow transplant services, for a one year period commencing August 23, 2013. The Hospital will need to file a renewal application for review to be considered for continued participation.

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

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION	*	**COMMISSION**	
JOHNS HOPKINS HEALTH	*	**DOCKET:**	**2013**
SYSTEM	*	**FOLIO:**	**2026**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2216A**

Staff Recommendation

Approved

July 10, 2013

I. INTRODUCTION

Johns Hopkins Health System ("System") filed an application with the HSCRC on June 16, 2013 on behalf of Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center (the Hospitals) for renewal of a renegotiated alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System requests approval from the HSCRC to continue to participate in a global rate arrangement for solid organ and bone marrow transplant services with Blue Cross Blue Shield Blue Distinction Centers for Transplants for a period of one year beginning August 1, 2013

.

II. OVE RVIEW OF APPLICATION

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

III. FEE DEVELOPMENT

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

IV. IDENTIFICATION AND ASSESSMENT OF RISK

The Hospitals will continue to submit bills to JHHC for all contracted and covered services. J HHC 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 experience under this arrangement was unfavorable for the last year. However, the Hospitals have renegotiated the global prices and terms of the arrangement. After review, staff believes that the Hospitals can achieve favorable performance under this revised arrangement.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for solid organ and bone marrow transplant services for a one year period commencing August 1, 2013. 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.

Health Services Cost Review Commission

Update Factor Recommendation for FY2014 for Psychiatric and Specialty Hospitals

July 10, 2013

Background

At the June 5, 2013 Public Meeting of the Health Services Cost Review Commission (HSCRC), the HSCRC staff recommended a 1.65% update factor for all hospitals under the jurisdiction of the HSCRC. At that meeting, Dr. Steven Sharfstein, President and CEO of Sheppard Pratt Hospital, requested that a different update factor be approved for Psychiatric Hospitals since they are not included under the Medicare Waiver, and neither Medicare nor Medicaid is compelled by law to pay HSCRC approved rates. The Commissioners approved the update factor of 1.65% for acute care hospitals only and directed the staff to return at the July 10th public meeting with a final recommendation for Psychiatric and other Specialty Hospitals.

Review

HSCRC Staff contacted the Centers for Medicare and Medicaid Services (CMS) regarding its proposed update factor for psychiatric and other specialty hospitals. The Market Basket for these hospitals is different than that calculated and used for acute care hospitals. The Rehabilitation, Psychiatric, and Long Term Care (RPL) market basket reflects the operating and capital cost structures for freestanding inpatient rehabilitation facilities, freestanding inpatient psychiatric facilities, and long term care hospitals. The official RPL update will not be released until August of 2013.

Staff also met with representatives of the psychiatric hospitals who presented data from Medicare's Proposed Rules, which indicated that the most current estimate of the RPL Market Basket is 2.5%. The proposed rules (Federal Register/Vol. 78, No. 89/Wednesday, May 8, 2013) also indicated that the Affordable Care Act (ACA) required a 0.3% reduction be made. In addition, the ACA requires an additional productivity adjustment be made based on the 10 year moving average of changes in annual economy-wide private nonfarm business multifactor productivity (MFP). The most recent estimate of the MFP adjustment for the period ending FY 2014 would result in a 0.4% further reduction to the Market Basket of 2.5%

Recommendation

Therefore, the staff recommends an update factor of 1.8% (2.5%-0.3%-0.4%) for the three private psychiatric hospitals under the jurisdiction of the HSCRC.

Additionally, the staff recommends an update factor for the other Specialty Hospitals of 1.65% as previously recommended. The chronic beds at Levindale Geriatric Hospital are not only under the HSCRC jurisdiction, but also are included as part of the current waiver test. The Freestanding Emergency Rooms at Germantown, Queenstown, and Bowie are also under HSCRC jurisdiction, and Medicare and Medicaid are required to pay Commission approved rates. Finally, while Medicare and Medicaid are not required to pay Commission approved rates at Mt. Washington Pediatric Hospital, Medicaid has long ago agreed to pay Commission approved rates and has constantly received the same update factor as other acute care hospitals.

CRISP

Connecting Physicians With Technology to Improve Patient Care in Maryland

Chesapeake Regional Information System for Our Patients

CRISP Overview

HSCRC Update and Progress Report

July 10th, 2013

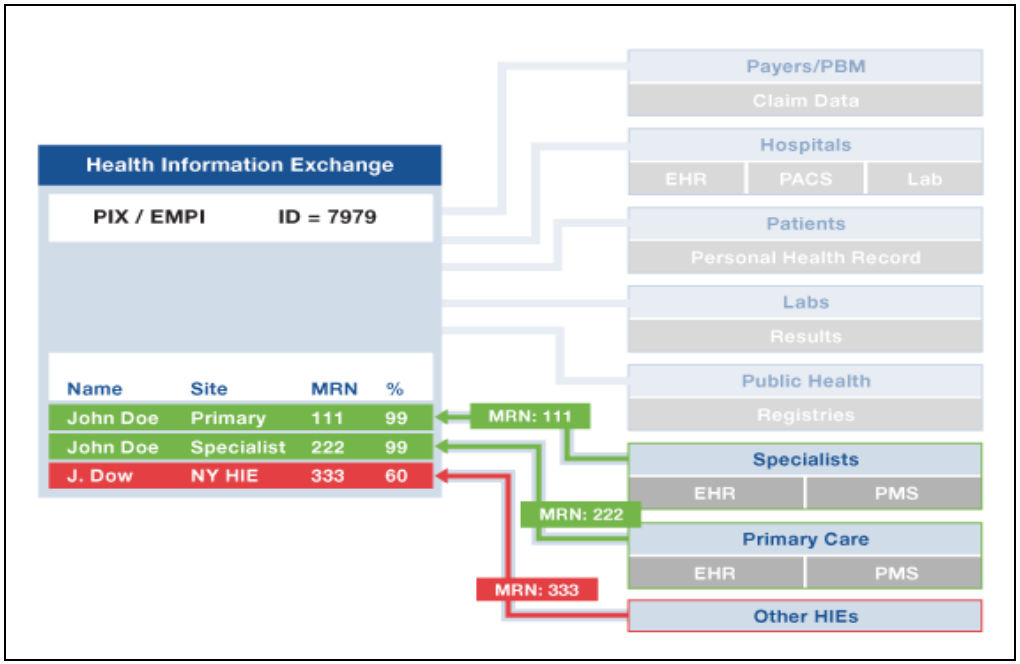
7160 Columbia Gateway Drive,
Suite 230
Columbia, Maryland 21046
1.877.95.CRISP (27477)
www.crisphealth.org

Background

- CRISP is Maryland's State Designated Entity for Health Information Exchange.
- CRISP began active HIE deployment work in 2010 after receiving designated by the MHCC and funding through an HSCRC rate modification.
- We exist to facilitate data sharing activities that are best pursued collaboratively.
- CRISP is a utility and resource for a range of health care stakeholder including providers, payers, communities, and policy makers.

Importance of Patient Identity Management

Chesapeake Regional Information System for Our Patients



The Challenge:

Accurately and consistently linking identities across multiple facilities to create a single view of a patient.

A near-zero tolerance of a false positive match rate with a low tolerance of a false negative match rate.

Accurate cross-entity patient identity management is a fundamental requirement for HIE generally, population-level measurement, utilization trending, and care coordination.

History of work with HSCRC

Beyond the financial partnership between CRISP and HSCRC our teams have been actively working together on an important effort.

- As HSCRC pursued readmission reimbursement initiatives, the lack of a unique patient ID prevented accurate analysis of inter-hospital readmissions.
- The existing CRISP MPI represented an opportunity to coordinate efforts, leverage existing infrastructure, and link a unique ID to HSCRC tape data.
- This approach was dependent on all hospitals sending real-time encounter data to CRISP which, with the support of HSCRC regulation, was achieved in January 2011.
- The core objective of our efforts is to accurately link a CRISP produced unique identifier to the existing HSCRC inpatient tape data to enable inter hospital analysis.

Progress on Linking HSCRC Hospital Data

- CRISP receives real-time encounter messages (called “ADTs”) which carry facility, medical record number, visit IDs, and other important information about visit.

- Unique Aspects of ADTs:
  - Real –Time data flows
  - Street address, enabling more granular level of geographic analysis

- As these messages flow through CRISP, we assign a unique ID using the MPI technology.

- Because the hospital reported tape data includes overlapping data elements (facility IDs, medical record numbers, visit IDs), we are able to add the unique CRISP ID to the tape data by matching the overlapping elements present in both data sets.

CRISP ID to HSCRC Data Link Rate

- We are able to match the CRISP ID and HSCRC record 99.8% of the time for all 46 hospitals
  - The match rate is above 99.2% for 44 of the 46 hospitals
  - We are working with one hospital on the crosswalk hospital of SSN to MRN because they submit SSN as MRN to HSCRC.
  - We are working with another hospital to isolate the cause of the +2% of missing matches.

- Most CRISP ID to HSCRC record linking issues are related to medical record number structure issues or changes in MRNs.

Opportunities to Use CRISP Data

- CRISP data can support care coordination activities and population-based analytics.
- Data is a shared resource to support policymakers, payers, and providers respond to new policy direction.
- CRISP tools: Master Patient Index, Real-Time Reporting, and Address Data, “linkable” data sets.

Encounter Notification Service (ENS)

- ENS enables CRISP participants (physicians, hospitals, payers) to receive real-time notifications when one of their patients or members is hospitalized.
- The alerts are generated from the “ADT” messages CRISP receives from all Maryland hospitals.
- Participants can only subscribe to “active patient or members”
- If an individual has opted out of the HIE, an alert will not be triggered.
- There are currently over **800,000 patients** subscribed to with in ENS resulting in over **1,250 notifications per day**.

Hospital Services Utilization Reporting

- As encounter messages flow into CRISP, reporting on aggregate hospital services, regional or community utilization, and trending analysis becomes possible.

- By consolidating, correlating, and reporting against real-time encounter data CRISP can produce rapid and comprehensive views of hospital data for purposes such as identifying (to the appropriate entity) “super-utilizers” in targeted geographies.

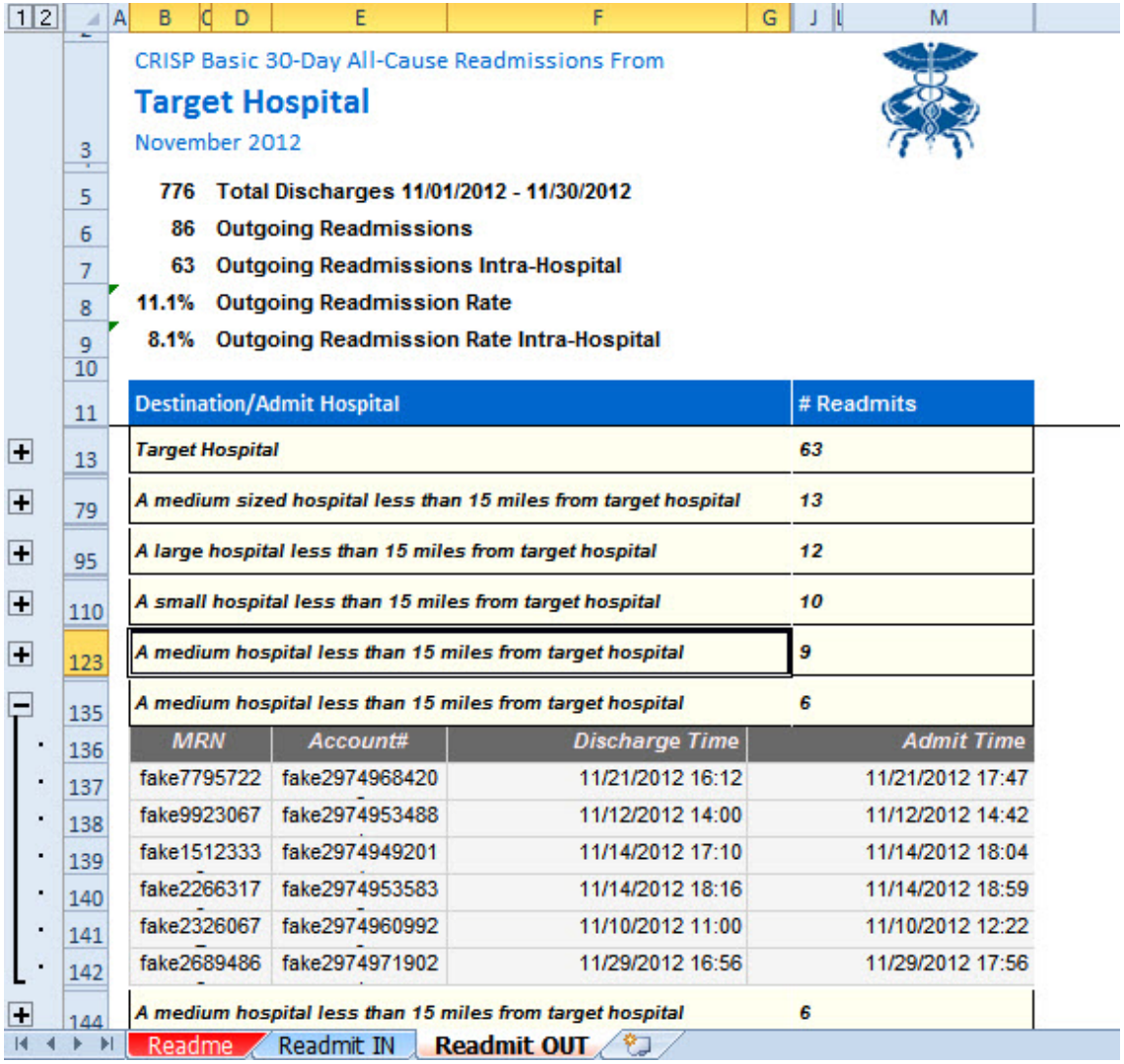
- January to March 2013 Inpatient Utilization

% Patients	# Patients	# Admits	# 30-Day Repeat	% Total Admits Admits/Tot Admits	% Total Repeat Repeats/Tot Repeats	30-day Repeat Rate Readmits/Admits
100%	138,764	167,002	8,084	100%	100%	5%
1%	1,388	6,502	1,588	4%	20%	24%
5%	6,939	21,487	4,073	13%	50%	19%
10%	13,877	35,363	5,787	21%	72%	16%
25%	34,692	62,892	7,467	38%	92%	12%
50%	69,383	97,598	7,664	58%	95%	8%

Encounter Reporting Service

Chesapeake Regional Information System for Our Patients

- 30-day all-cause inter-hospital repeat admission reports are being distributed monthly to most hospitals.
- These reports indicate how many patients have multiple admissions to any acute care hospital.
- We are working to provide utilization reporting that support hospital's efforts to perform well within value/risk-based reimbursement models.



CRISP Basic 30-Day All-Cause Readmissions From

Target Hospital

November 2012

776	Total Discharges 11/01/2012 - 11/30/2012
86	Outgoing Readmissions
63	Outgoing Readmissions Intra-Hospital
11.1%	Outgoing Readmission Rate
8.1%	Outgoing Readmission Rate Intra-Hospital

Destination/Admit Hospital	# Readmits
Target Hospital	*63*
A medium sized hospital less than 15 miles from target hospital	*13*
A large hospital less than 15 miles from target hospital	*12*
A small hospital less than 15 miles from target hospital	*10*
A medium hospital less than 15 miles from target hospital	*9*
A medium hospital less than 15 miles from target hospital	*6*

MRN	Account#	Discharge Time	Admit Time
fake7795722	fake2974968420	11/21/2012 16:12	11/21/2012 17:47
fake9923067	fake2974953488	11/12/2012 14:00	11/12/2012 14:42
fake1512333	fake2974949201	11/14/2012 17:10	11/14/2012 18:04
fake2266317	fake2974953583	11/14/2012 18:16	11/14/2012 18:59
fake2326067	fake2974960992	11/10/2012 11:00	11/10/2012 12:22
fake2689486	fake2974971902	11/29/2012 16:56	11/29/2012 17:56

A medium hospital less than 15 miles from target hospital	*6*

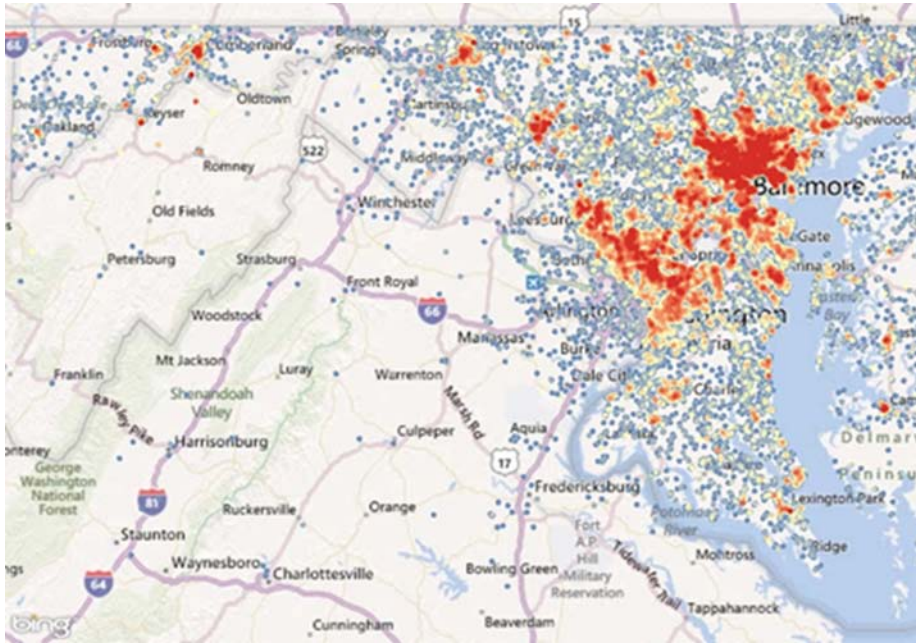
Readme | Readmit IN | Readmit OUT

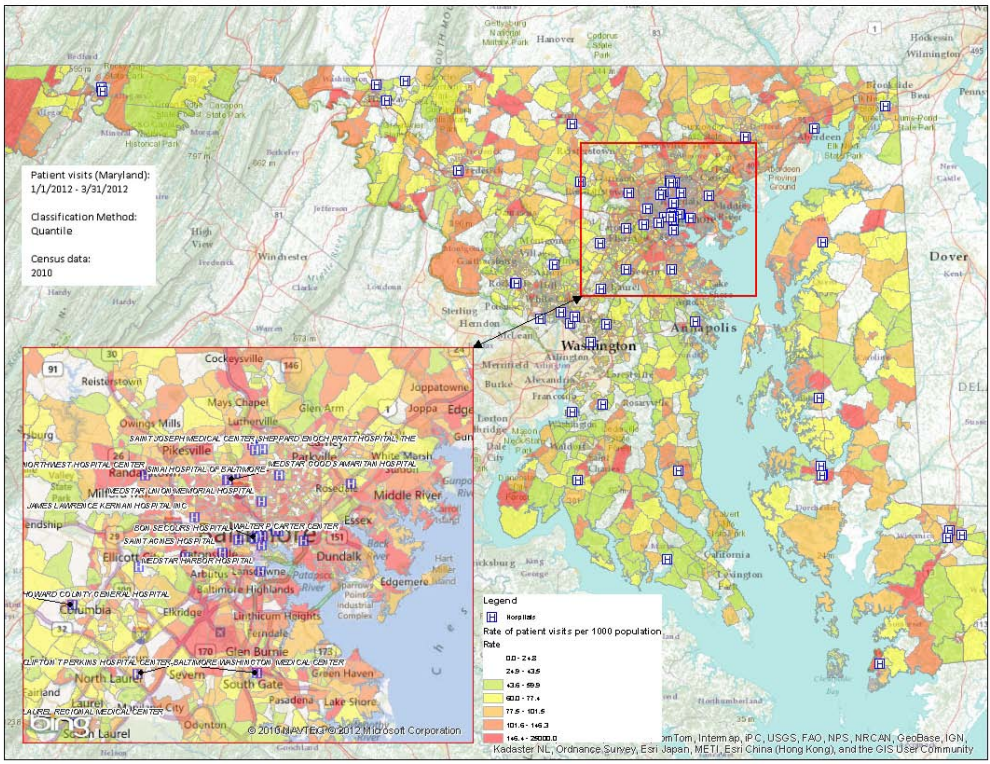
GIS Mapping Capability

Chesapeake Regional Information System for Our Patients

- Based on the indexed utilization information CRISP can produce visualizations of hospital utilization data in near real time.

- CIMH can leverage geographic data to better understand localized use of services and opportunities for the most efficient / targeted interventions.





CRISP Status Summary

Chesapeake Regional Information System for Our Patients

- CRISP was the first HIE in the country to connect all acute care hospitals.
- This important milestone is large part based on HSCRC support.

Progress Metric	Mar '12	May '13
Live Hospitals	48	48
Live Labs and Rad Centers (non-hosp)	5	7
Live Clinical Data Feeds	55	98
Identities in MPI	~2.8M	~5.4M
Lab Results Available	~7.8M	~29M
Radiology Report Available	~ 2.4M	~8M
Clinical Documents Available	~ 1.1M	~4M
Opt-Outs	798	2,031
Queries (past 30 days)	887	14,700
Notifications (past 30 days)	0	34,000
Participating physicians (query & notification)	129	1081

CRISP Next Steps

- Expanding HIE data submission to include all outpatient visits
- Linking HIE data with HSCRC case mix data to provide comprehensive reports to providers regarding readmissions and utilization patterns for their patients
- Supporting HSCRC population-based methodologies through more granular analytics

Expansion of Required Health Information Exchange Data to Support Population-based Methodologies

DRAFT STAFF RECOMMENDATION

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

July 10, 2013

These draft recommendations are for Commission consideration at the July 10, 2013 Public Commission Meeting. No action is required. Public comments should be sent to Claudine Williams at the above address or by e-mail at cwilliams@maryland.gov. For full consideration, comments must be received by July 30, 2013.

1. Introduction

The United States health care system currently experiences an unacceptably high rate of unnecessary hospital readmissions. These excessive readmission rates are a symptom of our fragmented payment system and result in considerable unnecessary cost and substandard care quality.

The HSCRC employs several methodologies that address this problem. Both the Total Patient Revenue ("TPR") and Admission-Readmission Revenue ("ARR") initiatives are designed to provide incentives for hospitals to improve overall care coordination and substantially reduce readmission rates. Ten hospitals are currently participating in the TPR structure — a global budget or capitated payment methodology covering a given hospital's inpatient and outpatient regulated facility charges. Thirty-one hospitals, including the four large health systems, participate in ARR episode payment structure. These methodologies represent important and urgently needed steps in the Commission's attempt to utilize its current regulatory authority to better rationalize Maryland's hospital payment and delivery system.

During the formulation of the ARR policy, the HSCRC determined that its existing data files did not provide enough information to link records reliably among hospitals. Furthermore, as Maryland moves towards population-based payment models and approaches, it will be necessary not only to link patient records across hospitals, but also across different care settings in order to develop effective payment models and strengthen existing methodologies.

HSCRC leveraged the already established infrastructure of the State's designated Health Information Exchange ("HIE"), a structure explicitly established and mandated to electronically connect all healthcare providers in the State. The HSCRC requires all hospitals to submit certain information for the creation of a unique state-wide patient identifier number will ultimately benefit the Commission, providers, payers, and most importantly, consumers.

2. CRISP Work To Date

Consistent with its chartered mandate to electronically connect all healthcare providers in the State, CRISP's infrastructure uses a hybrid-federated model that is supported by two technology vendors. Axolotl Corporation, an Ingenix company, provides the core infrastructure, and Initiate Systems, an IBM company, provides the master patient index ("MPI") technology. This technology allows CRISP to apply probabilistic algorithms to data received from an individual hospital and across hospitals (as well as other healthcare facilities) to uniquely identify patients with varying demographic data and different medical record numbers. The MPI assigns a patient identifier that cross-references all of the local medical record numbers from facilities, including from within a facility where IDs may have not matched accurately.

In the fall of 2010, CRISP began receiving clinical data from five hospitals, three large radiology centers, and two national labs. In April 2011, the Commission mandated that all Maryland acute care hospitals connect with the statewide HIE and submit primarily demographic data to

CRISP to create the unique patient ID. By January 2012, all 42 acute care hospitals were submitting the required data elements for all inpatient admissions. Currently, 44 hospitals are submitting some outpatient visits (primarily emergency room), and 42 hospitals are also submitting at least 1 live clinical feed (lab and radiology results, and other clinical documents). Twenty-four hospitals are sending all 3 clinical feeds.

To date, CRISP has created 5.4 million MPI numbers for Maryland patients and the statewide MPI matching rate for inpatient discharges is over 99 percent. HSCRC staff will now be able to track inpatient readmissions across hospitals; however, staff will not be able to link all outpatient services (such as observation) with inpatient readmissions.

3. Expansion of MPI to Outpatient Visits

The next phase of this project is to create MPI numbers for outpatient visits as well, to accurately assess hospital utilization across care settings and hospitals. The staff is proposing to require all hospitals to submit to CRISP the required data fields indicated below in Table 1 for all hospital outpatient visits, including emergency room, ambulatory, and same day surgery visits.

Table 1: Required Data Fields for Submission to CRISP

Field Name	HSCRC Outpatient New Requirement	HSCRC Outpatient Current Requirement
Name, First	Yes	
Name, Middle Initial	Yes	
Name, Last	Yes	
Address	Yes	
Address, City	Yes	
Address, State	Yes	
Address, Zip code	Yes	Yes
Date of Birth	Yes	Yes
Gender	Yes	Yes
Social Security Number	Yes[1]	
Visit/Encounter ID (VID)	Yes[2]	Yes
Medical Record Number (MRN)	Yes	Yes
Enterprise / System Level Patient ID	Yes[3]	Yes
Admission (From)Timestamp	Yes	Yes
Discharge (Thru) Timestamp	Yes	Yes

[1] Field required only if information is provided by patient

[2] This data field should be a unique number to identify a specific visit for a given patient

[3] If Hospital has an Enterprise ID in addition to the Medical Record Number

Using the patient information submitted by the hospital, CRISP will create a MPI for each unique patient using a probabilistic matching algorithm. CRISP will be required to provide reports to the HSCRC at the patient level which will include at least the following fields:

- MPI Number
- Hospital/Facility ID
- Medical Record Number
- From or Admission Date
- Thru or Discharge Date

The exact list of fields that will be required to match the report from CRISP to HSCRC's data set will be determined based on the analysis of a pilot data set. HSCRC may require CRISP to use an HSCRC algorithm to generate a supplemental HSCRC ID for purposes of matching against other hospital reported data.

4. Proposed Timeframe

Staff is proposing that the Commission require hospitals to submit the required data fields for all outpatient visits by December 1, 2013. HSCRC and CRISP staff will work with hospitals to submit the data through existing connectivity with CRISP.

5. Assignment of Unique IDs for CY 2012 data

As the development of population-based strategies necessitates complete historical data, staff is proposing that hospitals provide the required data fields listed in Table 1 for outpatient visits starting January, 1 2012 through December 31, 2012 to CRISP in order to create the MPI number. HSCRC staff will work with hospitals to determine the most efficient means, as well as the timeframe, for submitting these data to CRISP.

6. Recommendations

Staff recommends that the Commission approve the following recommendations:

1. Hospitals submit the expanded data elements outlined in Section 3 of this recommendation.
2. HSCRC publish data elements required for submission in the *Maryland Register* and on the Commission's website (http://www.hscrc.state.md.us).
3. HSCRC publish the format and data time period for submission in the *Maryland Register* and on the Commission's website.
4. Hospitals submit the required data elements for outpatients during CY 2012 to CRISP to create the MPI.
5. To provide flexibility to make changes to the required data elements that may change over time, the changes will be specified via the HSCRC website with a notice of change in the *Maryland Register*.
6. HSCRC use these data to support population-based methodologies and monitor Maryland's performance on hospital readmissions.

Maryland's Statewide Health Information Exchange, the Chesapeake Regional Information System for our Patients: HSCRC Funding and Status Report

July 3, 2013

Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

This is a report presented at the July 10, 2013 HSCRC public meeting.

Maryland's Statewide Health Information Exchange, the Chesapeake Regional Information System for our Patients: HSCRC Funding and Status Report

This report is to update the Commission on FY 2013 activities and accomplishments and on FY 2014 HSCRC funding support of the Chesapeake Regional Information System for our Patients (CRISP).

Background

In July of 2009 upon CRISP's designation as Maryland's Health Information Exchange (HIE) by the Maryland Health Care Commission (MHCC), it was with the conception that the HIE would create an interconnected, consumer-driven electronic health care system that would enhance our ability to improve health care quality, safety, and effectiveness, and reduce health care costs.

Based on CRISP's statewide HIE proposed technical approach that was flexible and protective yet not prohibitively restrictive, and financial approach that was sustainable, the HSCRC approved funding for CRISP to initiate the development of the statewide HIE through an adjustment to the rates of participating hospitals of up to $10 million over the subsequent 2-5 years. In accordance with the August 2009 approved recommendation, MHCC and HSCRC staff have reviewed annually CRISP deliverables and funding needs in order to determine whether adjustments should be made to the approved funding, with HSCRC having reserved the right to withhold or discontinue funding in the event that expectations were not met. For each of the past four years, all requested funding has been provided to CRISP.

Leveraging CRISP's HIE infrastructure, explicitly established and mandated to electronically connect all healthcare providers in the State, offered a "win-win" solution for creating a unique patient identifier that would benefit the Commission, providers, payers and most importantly, consumers. Therefore, in April of 2011, the Commission approved a recommendation requiring, through regulation, that all Maryland regulated hospitals establish connectivity with CRISP by December 1, 2011 to ensure full hospital participation as well as fair and accurate measurement of readmission performance.

Current CRISP HIE Activities, Other Projects, and HSCRC Funding

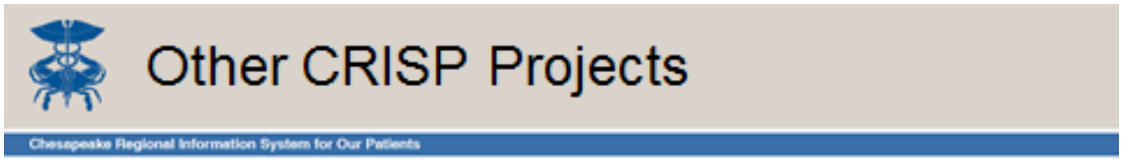
As indicated above, all hospitals are required to connect with CRISP and send "admission discharge transfer" ("ADT")/patient demographic data, making it the first HIE in the nation to connect all acute care hospitals in a state. CRISP has also worked to connect many other providers to the HIE. In addition to producing the unique patient identifier using Master Patient Index technology, CRISP has implemented a number of additional value added services, for example, its Encounter Notification System which provides patient encounter alerts to over 500 physicians for a patient panel of 750,000.

Maryland's Statewide Health Information Exchange, the Chesapeake Regional Information System for our Patients:

HSCRC Funding and Status Report

With a total annual operating budget projected at ~$11.8M for FY 2014, CRISP's breadth of work has grown significantly since 2009 with the addition of multiple funded projects and marked progress on implementation for these projects, demonstrating its sustainability and increasing value to multiple public and private entities. Table 1 below lists CRISP's projects in addition to the HIE work funded by the HSCRC and Federal HIE grants, and total funded dollar amounts for each of these projects estimated for FY 2014. In addition to these other grant-funded projects, in FY 2012 CRISP began generating revenue through user fees, and projects it will generate ~$1.45M in user fees for FY 2014.

Table 1. CRISP Estimated Grant Funding for Other Projects for FY 2014



Project	Funding
Prescription Drug Monitoring Program – implementation of a provider access portal	$750k
State Innovation Model grant – partner with DHMH for population health mapping and analysis	$450k
Medicaid IAPD – deploying new HIE functionality, such as single sign on, to Medicaid providers*	$2,600k
Regional Extension Center – Consulting assistance to PCPs deploying an EMR, through sub-grants	$1,250
Health Benefit Exchange – three projects to assist the HBE, one being a link with APCD data	$1,300
Challenge Grant – extending HIE functionality through sub-grants to long-term-care providers	$800k

*IAPD is Implementation Advance Planning Document which provides Federal Financial Participation (FFP) to Medicaid to conduct the implementation, management and oversight of Health Information Technology as allowed by the Centers for Medicare and Medicaid Services (CMS) final rule dated August 17, 2010

MHCC and HSCRC staff have reviewed CRISP's FY 2014 proposed budget. For this final year of HSCRC-approved HIE funding, CRISP will receive $1,166,278. Table 2 below illustrates the total HSCRC HIE funding amounts per year from 2010 through 2013.

Maryland's Statewide Health Information Exchange, the Chesapeake Regional Information System for our Patients:

HSCRC Funding and Status Report

Table 2. CRISP HIE Project HSCRC Funding 2010-2013

CRISP Budget: HSCRC Funds Received	
FY 2010	$4,650,000
FY 2011	No finds received
FY 2012	$2,869,967
FY 2013	$1,313,755
Total To Date	**$8,833,722**
Remaining Funds from $10 Million Allocation (FY 2014)	**$1,166,278**

HSCRC Support of CRISP Beyond FY 2014

As stated previously, CRISP has worked successfully thus far to secure added project work and funding sources. Moving forward beyond FY 2014, HSCRC and MHCC staff will continue to work with CRISP to develop key deliverables and milestones as the basis to determine any future HIE funding requests. HSCRC staff will bring a draft recommendation with pertinent details to the Commission for consideration in the fall of 2013.

Maryland Hospital Community Benefits Report
FY 2012

July 10, 2013

Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215
(410) 764-2605
FAX: (410) 358-6217

Introduction

Each year, the Health Services Cost Review Commission ("Commission," or "HSCRC") collects community benefit information from individual hospitals to compile into a publicly-available statewide Community Benefit Report ("CBR"). This document contains summary information for all submitting Maryland hospitals for FY 2012. Past and current year's CB reports submitted by the individual hospitals are available at the Commission offices. HSCRC staff will also make hospital-specific CB reports and corresponding data available on the Commission's website this month. Past year's reports and corresponding data are currently available on the Commission's website.

Background

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

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

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

In March 2010, Congress passed the Patient Protection and Affordable Care Act ("ACA"). Under the ACA, every § 501(c)(3) hospital, whether independent or in a system, must conduct a community health needs assessment at least once every three years in order to maintain its tax-exempt status and avoid an annual penalty of up to $50,000. The first needs assessment will be due by the end of a hospital's fiscal year 2013 (by June 30, 2013 for a June 30 YE hospital). Each community health needs assessment must take into account input from persons who represent the broad interest of the community served, including those with special knowledge or expertise in public health, and the assessment must be made widely available to the public. An implementation strategy describing how a hospital will meet the community's health needs must be included, as well as a description of what the hospital has done historically to address its community needs. Furthermore, the hospital must identify any needs that have not been met by the hospital and why these needs have not been addressed. Tax exempt hospitals must report this information on Schedule H of the IRS 990 forms.

The Maryland CBR process was introduced by the Maryland legislature in 2001 (Health-General Article, §19-303 Maryland Annotated Code), with FY 2004 set as the first data collection period. The Commission worked with the Maryland Hospital Association ("MHA") and interested hospitals, local health departments, and health policy organizations and associations on the details and format of the community benefit report. In developing the format for data collection, the group drew heavily on the experience of the Voluntary Hospitals of America ("VHA") community benefit process, which possessed, at that time, over ten years of voluntary hospital community benefit reporting experience across many states. The resulting data reporting spreadsheet and instructions were used by Maryland hospitals to submit the FY 2004 data to the Commission in January 2005. The Commission's first CBR, detailing the FY 2004 data, was published in July 2005.

The HSCRC continues to work with MHA, public health officials and individual hospitals to further improve the reporting process and to refine definitions as needed. The data collection process offers an opportunity for each Maryland non-profit, acute care hospital to critically review and report its activities designed to benefit the community it serves.

The Fiscal Year 2012 report represents the HSCRC's ninth year of reporting on Maryland hospital community benefit data.

Definition of Community Benefits

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

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

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

[1] Southern Maryland Hospital, the only for-profit hospital in Maryland, is not required to submit a community benefits report under the law. However, they have continued to submit a community benefit report to the HSCRC. In December, 2012, Southern Maryland Hospital was purchased by MedStar and became a non-profit acute care hospital. Beginning with FY 2013, MedStar Southern Maryland Hospital Center will file a complete Community Benefit Report.

CBR – 2012 Data Highlights

The reporting period for this CBR is July 1, 2011 – June 30, 2012. Hospitals submitted their individual community benefit reports to the HSCRC by December 15, 2012 using audited financial statements as the source for calculating costs in each of the community benefit categories.

As shown in Table I below, Maryland hospitals provided approximately $1.4 billion dollars in total community benefit activities in FY 2012 (up from $1.2 billion in FY 2011). This total is comprised of $56.4 million in Unreimbursed Medicaid Cost, $92.8 million in Community Health Services, more than $370 million in Health Professions Education, $316 million in Mission Driven Health Care Services, $6.7 million in Research activities, just over $14.2 million in Financial Contributions, $23.2 million in Community Building Activities, over $8.6 million in Community Benefit Operations, and over $2 million in Foundation Funded Community Benefits.[2] Maryland hospitals reported providing over $487 million in Charity Care.

In Maryland, the costs of uncompensated care (both charity care and bad debt) and graduate medical education are built into rates for which hospitals are reimbursed by all payers, including Medicare and Medicaid. Additionally, the HSCRC includes amounts in rates for hospital nurse support programs provided at Maryland hospitals. These costs are, in essence, "passed-through" to the purchasers and payers of hospital care. To be consistent with IRS form 990 requirements and to avoid accounting confusion among programs that are not funded in part by hospital rate setting (unregulated), the HSCRC requested that hospitals not include revenue provided in rates as offsetting revenue on the CBR worksheet. Attachments III, IV, and V detail the amounts that are included in rates and funded by all payers for charity care, direct graduate medical education, and the nurse support program in Fiscal Year 2012.

As noted, the HSCRC includes a provision in hospital rates for uncompensated care; this includes charity care (eligible for inclusion as a community benefit by Maryland hospitals in their CBRs) and bad debt (not considered a community benefit). As detailed in Attachment III, just over $442 million in charity care was provided through Maryland hospital rates in FY 2012 that was funded by all payers. When offset against the hospital reported amount of over $487 million in charity care, the net amount provided by hospitals is over $45 million.

Also as noted, another social cost funded in Maryland's rate-setting system is the cost of graduate medical education, generally for interns and residents trained in Maryland hospitals. Included in graduate medical education costs are the direct costs (Direct Medical Education or "DME"), which constitute wages and benefits of residents and interns, faculty supervisory expenses, and allocated overhead. The Commission utilizes its annual cost report to quantify the DME costs of physician training programs at Maryland hospitals. In FY 2012, these DME costs totaled $272.3 million. Attachment IV shows DME costs by hospital.

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

The Commission's Nurse Support Program I (NSPI) is aimed at addressing the short and long-term nursing shortage impacting Maryland hospitals. In FY 2012, over $12.2 million was provided in hospital rate adjustments for NSPI. For further information about funding provided to specific hospitals, please see Attachment V.

Table I – Total Community Benefit

Community Benefit Category	Number of Staff Hours	Number of Encounters	Total Community Benefit w/Rate Support	Percent of Total CB Expenditures	Total Community Benefit w/o Rate Support	Percent of Total CB Expenditures w/o Rate Support
Unreimbursed Medicaid Cost			$56,475,885	4.09%	$56,475,885	8.67%
Community Health Services	899,742	14,862,013	$92,854,825	6.73%	$92,854,825	14.25%
Health Professions Education	5,275,842	258,412	$370,536,944	26.88%	$85,930,714	13.19%
Mission Driven Health Services	2,200,956	892,488	$316,119,768	22.94%	$316,119,768	48.51%
Research	108,646	7,600	$6,744,602	0.49%	$6,744,602	1.03%
Financial Contributions	41,136	280,904	$14,273,148	1.04%	$14,273,148	2.19%
Community Building	109,327	609,036	$23,244,560	1.69%	$23,244,560	3.57%
Community Benefit Operations	68,592	9,480	$8,633,164	0.63%	$8,633,164	1.32%
Foundation	56,197	43,156	$2,286,628	0.17%	$2,286,628	0.35%
Charity Care	n/a	n/a	$487,132,406	35.34%	$45,123,522	6.92%
Total	8,760,439	16,963,087	$1,378,301,930	100%	$651,686,816	100%

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

When looking at the expenditures in each category as a percentage of total expenditures (see Figure 1) Charity Care, Health Professions Education and Mission Driven Health Services take up the majority of the pie at 35.34%, 26.88%, and 22.94%, respectively. However, when considering the expenditures without amounts provided in rates (see Figure 2) the configuration changes significantly, moving Mission Driven Health Services (subsidized health services) into

the largest category at 48.51%. Community Health Services and Health Professions Education follow with 14.25% and 13.19% of expenditures, respectively.

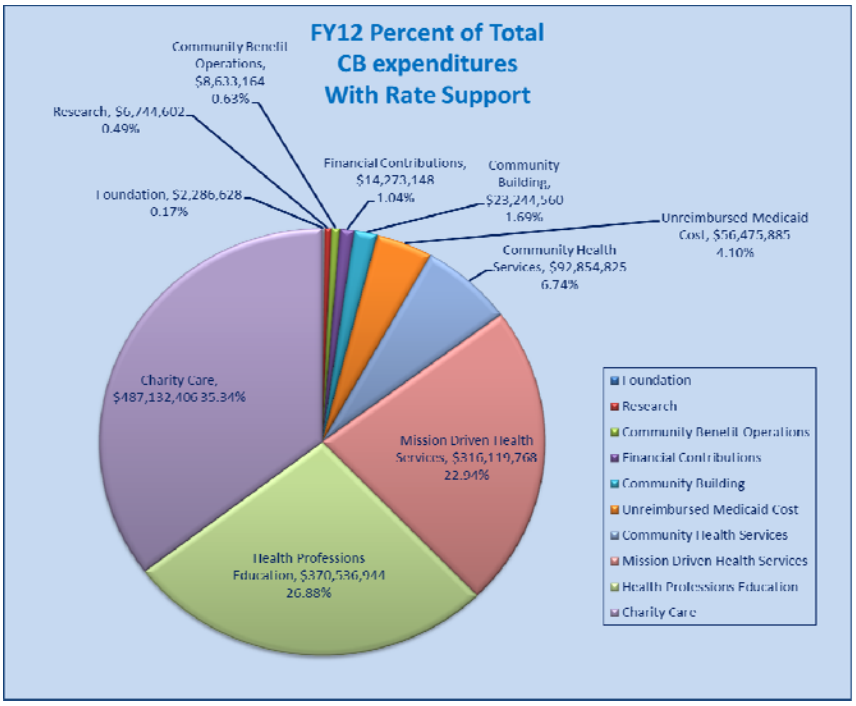


Figure 1

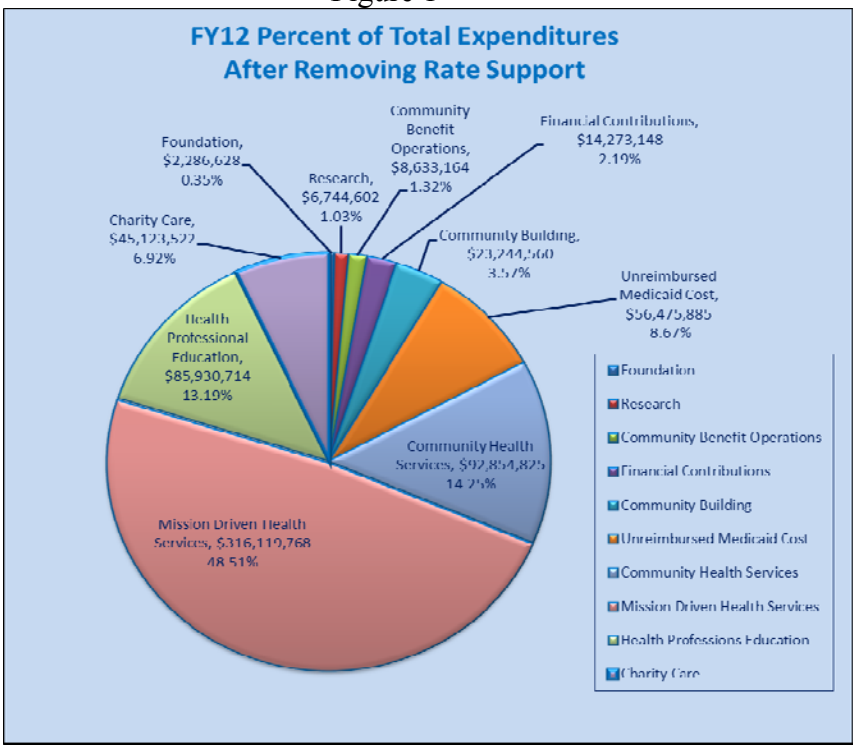


Figure 2

Utilizing the data reported, Attachment II of the FY 2012 CB Analysis compares hospitals on the total amount of community benefits reported, the amount of community benefits that are recovered though HSCRC approved rates (charity care, direct medical education, and nurse support), and the number of staff dedicated to community benefit operations. On average, in FY 2012, 1,491 staff hours were dedicated to CB Operations. This is up by 246 hours from last year's average of 1,245. There are nine hospitals reporting zero staff hours dedicated to CB Operations. The HSCRC continues to encourage hospitals to incorporate CB Operations into their overall strategic planning.

The total amount of community benefit expenditures as a percentage of total operating expenses ranges from 3.21% to 26.31% with the average percentage being 10.06%. This has increased from FY 2011's average of 9.23%. There are twenty hospitals that report providing benefits in excess of 10% of their operating expenses, as compared to sixteen in FY 2011. Thirty-one hospitals exceed 7.5%. No hospitals report spending less than 3% of their operating expenses on community benefit compared to two hospitals last year.

When these costs are offset by rate support, the net community benefit provided by Maryland hospitals in FY 2012 was $ 651.6 million, or 4.82% of the total hospital operating expenses. This is up from the $580.4 million in net benefits provided in FY 2011, which totaled approximately 4.45% of hospitals' operating expenses. Please see the chart in Attachment II for more detail.

CBR 2012 – Narrative Highlights

In FY 2012, hospitals were again asked to respond to narrative questions regarding their CB programs. The questions were developed, in part, to provide a standard reporting format for all hospitals. This uniformity not only provided readers of the individual hospital reports with more information than was previously available, but also allowed for comparisons across hospitals. The narrative guidelines were aligned, wherever possible, with the IRS form 990, schedule H, in an effort to provide as much consistency as is practicable in reporting on the State and federal levels.

The HSCRC also considers the narrative guidelines to be a mechanism for assisting hospitals in critically examining their CB programs. Any examination of the effectiveness of major program initiatives should help hospitals determine which programs are achieving the desired results and which are not.

Hospitals were asked to include a list of unmet health needs which were identified through the most recent community health needs assessment, but which remain unaddressed due to a variety of circumstances. The most prevalent unmet health need noted in the FY2012 reports was behavioral/mental health/substance abuse. Other unmet health needs, consistently identified, were environment/air quality problems, transportation, and child/adult obesity. Some hospitals indicated these needs were to be addressed by other organizations within the community as well as a lack of expertise at the hospital as reasons for not addressing the identified needs.

The evaluation tool, resulting from the HSCRC advisory group was again used to evaluate hospitals' Community Benefit Narrative Reports. The group of evaluators consisted of three individuals, a member of HSCRC staff, a representative of the Maryland Hospital Association, and public health official from the Department of Health and Mental Hygiene (DHMH). FY 2012 showed much improvement in the narrative reporting process. The total points available were 144. Of the 45[3] hospitals evaluated, the average score was 137, or 95.05%. Four of the submissions earned 100%, seven of the submissions were above 90%, with all but one of the remaining earning between 80 and 90%. One hospital was below 80% because it used the prior year's instructions for the submission, and was therefore missing select items. The section of the narrative report that lost most points, on average, was section IV, which requests information on the CB programs and initiatives. The evaluators found that in many instances, more detail was needed about the target population (who is impacted?); the interventions used (what action is producing change?); the link between the target population and the interventions (are these evidence based interventions?); and data supported outcomes (what measures are used to determine success?).

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

All acute hospitals will have completed their first CHNA in accordance with the ACA, by the end of FY13. To simplify the process for the FY13 report, hospitals will be able to include appropriate portions of their CHNA to answer narrative questions. The HSCRC expects to see improvements in section IV-CB Programs and Initiatives in light of the CHNA process.

[3] Southern Maryland Hospital files the data portion of the report in the format prescribed. However, since it is exempt from the community benefit reporting requirements, the narrative portion of their submission is not in the format prescribed and has been excluded from the evaluation process.

Attachment I – FY 2012 CB Aggregate Data

FY2012 CBR Totals

	UNREIMBURSED MEDICAID COST	# OF STAFF HOURS	# OF ENCOUNTERS	DIRECT COST($)	INDIRECT COST($)	Offsetting Revenue	Net Community Benefit W/Indirect Cost	Net Community Benefit W/O Indirect Cost
T00	**Medicaid Costs**							
T99	Medicaid Assessments	0	0	$389,825,000	$0	$333,349,115	$56,475,885	$56,475,885

	COMMUNITY BENEFIT ACTIVITES	# OF STAFF HOURS	# OF ENCOUNTERS	Direct Cost ($)	Indirect Cost ($)	Offsetting Revenue	Net Community Benefit W/Indirect Cost	Net Community Benefit W/O Indirect Cost
A00.	**COMMUNITY HEALTH SERVICES**							
A10	Community Health Education	234,785	13,818,884	$18,363,355	$10,195,307	$1,741,330	$26,817,332	$16,622,025
A11	Support Groups	18,608	37,263	$779,134	$437,109	$23,873	$1,192,370	$755,260
A12	Self-Help	29,407	114,344	$1,520,330	$800,544	$932,429	$1,388,445	$587,901
A20	Community-Based Clinical Services	301,541	442,634	$16,555,997	$3,824,213	$739,305	$19,640,906	$15,816,692
A21	Screenings	24,860	87,545	$2,206,952	$1,181,817	$351,459	$3,037,310	$1,855,493
A22	One-Time/Occasionally Held Clinics	1,865	12,517	$243,308	$105,978	$80,980	$268,306	$162,328
A23	Free Clinics	12	71	$75,021	$42,840	$67,726	$50,136	$7,295
A24	Mobile Units	20,014	8,784	$1,101,445	$382,752	$709,765	$774,433	$391,680
A30	Health Care Support Services	214,500	242,181	$22,962,158	$9,969,717	$787,560	$32,144,315	$22,174,598
A40	Other	54,149	97,790	$4,404,758	$3,187,637	$51,122	$7,541,274	$4,353,636
A99	**Total Community Health Services**	899,742	14,862,013	$68,212,459	$30,127,915	$5,485,549	$92,854,825	$62,726,910

		# OF STAFF HOURS	# OF ENCOUNTERS	Direct Cost ($)	Indirect Cost ($)	Offsetting Revenue	Net Community Benefit W/Indirect Cost	Net Community Benefit W/O Indirect Cost
B.	**HEALTH PROFESSIONS EDUCATION**							
B1	**Physicians/Medical Students**	4,461,908	21,933	263,293,998	63,069,533	0	326,363,531	$263,293,998
B2	Nurses/Nursing Students	453,604	118,793	19,710,285	6,151,815	335,954	25,526,146	$19,374,331
B3	Other Health Professionals	212,236	80,692	9,287,566	1,449,644	126,160	10,611,050	$9,161,406
B4	Scholarships/Funding for Professional Education	6,989	698	2,648,153	3,163	47,299	2,604,017	$2,600,854
B5	**Other**	141,104	36,297	5,180,167	325,511	73,478	5,432,200	$5,106,689
B99	**Totals**	5,275,842	258,412	$300,120,170	$70,999,665	$582,890	$370,536,944	$299,537,279

		# OF STAFF HOURS	# OF ENCOUNTERS	Direct Cost ($)	Indirect Cost ($)	Offsetting Revenue	Net Community Benefit W/Indirect Cost	Net Community Benefit W/O Indirect Cost
C.	MISSION DRIVEN HEALTH SERVICES							
	Totals	2,200,956	892,488	$363,387,868	$83,681,981	$130,950,082	$316,119,768	$232,437,787

		# OF STAFF HOURS	# OF ENCOUNTERS	Direct Cost ($)	Indirect Cost ($)	Offsetting Revenue	Net Community Benefit W/Indirect Cost	Net Community Benefit W/O Indirect Cost
D.	RESEARCH							
D1	Clinical Research	96,283	7,097	5,263,307	1,618,225	1,619,303	5,262,230	$3,644,005
D2	Community Health Research	363	438	147,124	6,998	0	154,122	$147,124
D3	Other	12,000	65	833,985	494,265	0	1,328,250	$833,985
D99	Totals	108,646	7,600	$6,244,416	$2,119,488	$1,619,303	$6,744,602	$4,625,114

		# OF STAFF HOURS	# OF ENCOUNTERS	Direct Cost ($)	Indirect Cost ($)	Offsetting Revenue	Net Community Benefit W/Indirect Cost	Net Community Benefit W/O Indirect Cost
E.	Financial Contributions							
E1	Cash Donations	1,029	75,786	7,868,370	408,109	239,091	8,037,388	$7,629,279
E2	Grants	6,182	431	561,976	30,580	193,922	398,634	$368,054
E3	In-Kind Donations	32,699	176,375	4,918,420	605,277	206,776	5,316,921	$4,711,644
E4	Cost of Fund Raising for Community Programs	1,227	28,312	422,737	97,468	0	520,205	$422,737
E99	Totals	41,136	280,904	$13,771,502	$1,141,435	$639,789	$14,273,148	$13,131,713

F.	COMMUNITY BUILDING ACTIVITIES	# OF STAFF HOURS	# OF ENCOUNTERS	Direct Cost ($)	Indirect Cost ($)	Offsetting Revenue	Net Community Benefit W/Indirect Cost	Net Community Benefit W/O Indirect Cost
F1	Physical Improvements/Housing	10,141	312,453	$3,576,660	$196,168	$2,779,792	$993,036	$796,868
F2	Economic Development	3,372	6,228	$1,358,308	$658,339	$394,731	$1,621,916	$963,577
F3	Support System Enhancements	23,217	32,841	$2,328,984	$1,299,046	$116,273	$3,511,757	$2,212,711
F4	Environmental Improvements	10,596	5,620	$2,624,631	$231,613	$0	$2,856,244	$2,624,631
F5	Leadership Development/Training for Community Members	2,750	1,172	$198,979	$103,176	$0	$302,155	$198,979
F6	Coalition Building	8,856	47,644	$1,027,132	$470,363	$161	$1,497,334	$1,026,971
F7	Community Health Improvement Advocacy	4,199	5,349	$1,184,871	$468,729	$47,922	$1,605,677	$1,136,949
F8	Workforce Enhancement	23,054	17,520	$2,757,632	$1,492,294	$13,200	$4,236,726	$2,744,432
F9	Other	21,907	180,209	$1,551,026	$682,172	$6,575	$2,226,623	$1,544,451
F10	Other	1,235	0	$51,870	$26,921	$0	$78,791	$51,870
F11	Sales Tax, Property Tax, Income Taxes	0	0	$4,314,302	$0	$0	$4,314,302	$4,314,302
F99	Totals	109,327	609,036	$20,974,393	$5,628,821	$3,358,654	$23,244,560	$17,615,739

G.	COMMUNITY BENEFIT OPERATIONS	# OF STAFF HOURS	# OF ENCOUNTERS	Direct Cost ($)	Indirect Cost ($)	Offsetting Revenue	Net Community Benefit W/Indirect Cost	Net Community Benefit W/O Indirect Cost
G1	Dedicated Staff	59,116	874	$4,098,176	$1,556,491	$0	$5,654,666	$4,098,176
G2	Community health/health assets assessments	8,893	4,292	$688,482	$339,659	$0	$1,028,140	$688,482
G3	Other Resources	528	314	$1,287,461	$670,082	$10,355	$1,947,188	$1,277,106
G4		25	4,000	$1,042	$398	$0	$1,440	$1,042
G5		30	0	$1,251	$478	$0	$1,729	$1,251
G99	Totals	68,592	9,480	$6,076,412	$2,567,107	$10,355	$8,633,164	$6,066,057

H.	CHARITY CARE (report total only)	
		$487,132,406

J.	FOUNDATION COMMUNITY BENEFIT	# OF STAFF HOURS	# OF ENCOUNTERS	Direct Cost ($)	Indirect Cost ($)	Offsetting Revenue	Net Community Benefit W/Indirect Cost	Net Community Benefit W/O Indirect Cost
J1	Community Services	10,398	2,185	$695,232	$91,478	$8,078	$778,632	$687,154
J2	Community Building	45,799	40,971	$1,452,747	$55,249	$0	$1,507,996	$1,452,747
J99	Totals	56,197	43,156	$2,147,979	$146,727	$8,078	$2,286,628	$2,139,901

		# OF STAFF HOURS	# OF ENCOUNTERS	Direct Cost ($)	Indirect Cost ($)	Offsetting Revenue	Net Community Benefit W/Indirect Cost	Net Community Benefit W/O Indirect Cost
K	TOTAL HOSPITAL COMMUNITY BENEFIT							
A	Community Health Services	899,742	14,862,013	68,212,459	30,127,915	5,485,549	92,854,825	62,726,910
B	Health Professions Education	5,275,842	258,412	$300,120,170	$70,999,665	$582,890	$370,536,944	$299,537,279
C	Mission Driven Health Care Services	2,200,956	892,488	$363,387,868	$83,681,981	$130,950,082	$316,119,768	$232,437,787
D	Research	108,646	7,600	$6,244,416	$2,119,488	$1,619,303	$6,744,602	$4,625,114
E	Financial Contributions	41,136	280,904	$13,771,502	$1,141,435	$639,789	$14,273,148	$13,131,713
F	Community Building Activities	109,327	609,036	$20,974,393	$5,628,821	$3,358,654	$23,244,560	$17,615,739
G	Community Benefit Operations	68,592	9,480	$6,076,412	$2,567,107	$10,355	$8,633,164	$6,066,057
H	Charity Care	0	0	$487,132,406	$0	$0	$487,132,406	$487,132,406
J	Foundation Funded Community Benefit	56,197	43,156	$2,147,979	$146,727	$8,078	$2,286,628	$2,139,901
T99	Medicaid Assessments	0	0	$389,825,000	$0	$333,349,115	$56,475,885	$56,475,885
K99	TOTAL HOSPITAL COMMUNITY BENEFIT	8,760,439	16,963,087	$1,657,892,606	$196,413,139	$476,003,815	$1,378,301,930	$1,181,888,791

TOTAL OPERATING EXPENSE	$13,532,154,004
% OF OPERATING EXPENSES W/IC	10.19%
% OF OPERATING EXPENSES W/O IC	8.73%

Attachment II – FY 2012 CB Analysis

Hospid	Hospital Name	Employees	Total Staff Hours CB Operations	Total Hospital Operating Expense	Total Community Benefit	Total CB as % of Total Operating Expense	FY 2012 Amount in Rates for Charity Care, DME, and NSPI	Total Net CB minus Chairty Care, DME, NSPI in Rates	Total Net CB(minus charity Care, DME, NSPI in Rates) as % of Operating Expense	CB Reported Charity Care	Point Totals for Sufficiency of Narrative Answers	% Totals for Sufficiency of Narrative Answers	
60	Fort Washington	469	0	$42,060,748	$1,349,387	3.21%	$802,089	$547,298	1.30%	$687,534	116	80.56%	
51	Doctors	1497	700	$191,007,547	$8,006,647	4.19%	$3,025,218	$4,981,429	2.61%	$2,949,975	140	97.22%	
7	St. Joseph	1920	111	$317,898,969	$13,913,458	4.38%	$4,311,296	$9,602,162	3.02%	$5,450,082	130	90.28%	
44	GBMC	2640	0	$394,015,000	$19,306,872	4.90%	$10,727,415	$8,579,457	2.18%	$4,891,152	110	76.39%	
49	UCH-Upper Chesapeake	1906	0	$212,644,000	$10,917,442	5.13%	$4,699,360	$6,218,082	2.92%	$3,498,417	138	95.83%	
45	McCready	275	80	$21,636,518	$1,132,766	5.24%	$693,472	$439,294	2.03%	$745,292	116	80.56%	
54	Southern Maryland	1778	0	$238,296,345	$13,083,123	5.49%	$2,793,333	$10,289,790	4.32%	$1,038,210	N/A		
23	Anne Arundel	3955	1,100	$500,951,000	$29,448,047	5.88%	$5,621,957	$23,826,090	4.76%	$6,430,100	139	96.53%	
32	Union Cecil County	1092	2,359	$143,517,898	$8,942,270	6.23%	$2,516,086	$6,426,184	4.48%	$2,772,924	139	96.53%	
19	Peninsula	2725	171	$374,161,000	$24,179,071	6.46%	$9,487,294	$14,691,777	3.93%	$13,903,600	142	98.61%	
35	Civista	809	3,601	$103,688,628	$6,909,155	6.66%	$1,292,719	$5,616,436	5.42%	$1,346,317	141	97.92%	
33	Carroll Hospital	1750	20	$211,404,000	$14,918,395	7.06%	$2,949,187	$11,969,208	5.66%	$2,902,549	141	97.92%	
6	UCH-Harford	842	0	$89,609,000	$6,396,189	7.14%	$2,399,226	$3,996,963	4.46%	$2,693,329	138	95.83%	
5	Frederick Memorial	2209	0	$349,290,000	$25,675,260	7.35%	$6,772,553	$18,902,707	5.41%	$8,977,168	122	84.72%	
40	Northwest	1615	3,053	$216,497,000	$15,916,900	7.35%	$3,274,769	$12,642,131	5.84%	$3,134,970	139	96.53%	
2004	Good Samaritan	2385	2,068	$299,758,071	$24,498,030	8.17%	$11,587,501	$12,910,529	4.31%	$7,313,699	144	100.00%	
15	Franklin Square	3583	4,366	$436,640,459	$36,067,017	8.26%	$19,101,694	$16,965,323	3.89%	$12,654,205	143	99.31%	
18	Montgomery General	1350	524	$137,669,098	$11,669,996	8.48%	$5,454,259	$6,215,737	4.51%	$5,899,800	143	99.31%	
22	Suburban	1842	1,846	$239,149,257	$20,408,406	8.53%	$4,546,769	$15,861,637	6.63%	$4,445,433	144	100.00%	
12	Sinai	4685	6,428	$691,053,000	$61,389,921	8.88%	$30,971,674	$30,418,247	4.40%	$11,933,267	142	98.61%	
5050	Shady Grove	2085	1,320	$293,106,862	$26,379,103	9.00%	$8,536,074	$17,843,029	6.09%	$8,871,895	142	98.61%	
28	St. Mary's	1105	2,160	$121,640,602	$10,971,558	9.02%	$4,972,520	$5,999,038	4.93%	$4,836,119	144	100.00%	
17	Garrett County	321	408	$38,394,160	$3,525,530	9.18%	$1,637,350	$1,888,180	4.92%	$2,865,474	139	96.53%	
11	St. Agnes	2769	0	$379,701,946	$35,393,572	9.32%	$24,003,548	$11,390,024	3.00%	$21,195,691	123	85.42%	
48	Howard County	1975	1,515	$230,182,000	$21,630,475	9.40%	$5,740,167	$15,890,308	6.90%	$6,269,194	136	94.44%	
1	Meritus Medical Center	2383	285	$283,953,366	$27,445,984	9.67%	$10,514,947	$16,931,037	5.96%	$13,422,389	120	83.33%	
37	Shore Health - Easton	1330	4,326	$158,501,000	$15,915,558	10.04%	$8,407,998	$7,507,560	4.74%	$9,844,900	141	97.92%	
38	Maryland General	1200	862	$179,896,000	$18,327,883	10.19%	$18,637,284	($309,401)	-0.17%	$15,217,000	138	95.83%	
61	Atlantic General	811	88	$91,074,982	$9,408,149	10.33%	$2,345,200	$7,062,949	7.76%	$2,497,958	140	97.22%	
9	Johns Hopkins	8997	5,394	$1,725,787,000	$180,588,004	10.46%	$143,329,016	$37,258,988	2.16%	$32,982,000	143	99.31%	
2001	Kernan	695	755	$103,473,000	$11,242,929	10.87%	$6,729,020	$4,513,909	4.36%	$3,165,000	137	95.14%	
43	Baltimore Washington	2753	95	$325,035,000	$36,372,119	11.19%	$17,245,641	$19,126,478	5.88%	$21,373,238	142	98.61%	
24	Union Memorial	2494	140	$397,245,796	$44,602,381	11.23%	$22,374,039	$22,228,342	5.60%	$14,855,717	138	95.83%	
29	JH Bayview	3550	598	$543,333,000	$63,008,262	11.60%	$42,109,514	$20,898,748	3.85%	$25,308,000	142	98.61%	
34	Harbor Hospital	1412	212	$202,041,627	$23,875,943	11.82%	$11,590,753	$12,285,190	6.08%	$7,084,202	142	98.61%	
8	Mercy	2836	457	$399,668,124	$47,762,030	11.95%	$18,408,725	$29,353,305	7.34%	$14,458,293	140	97.22%	
4	Holy Cross	3198	6,402	$387,341,538	$47,004,122	12.14%	$17,761,963	$29,242,159	7.55%	$23,691,563	144	100.00%	
10	Shore Health -Dorchester	678	0	$43,326,000	$5,355,093	12.36%	$3,674,305	$1,680,788	3.88%	$3,579,500	141	97.92%	
27	Western MD Regional	2313	305	$304,887,833	$39,916,790	13.09%	$8,537,143	$31,379,647	10.29%	$15,948,853	142	98.61%	
16	Washington Adventist	1508	1,320	$224,511,599	$33,849,591	15.08%	$3,695,398	$30,154,193	13.43%	$10,766,256	142	98.61%	
2	University of Maryland	7999	1,522	$1,294,033,000	$196,676,464	15.20%	$162,129,381	$34,547,083	2.67%	$69,782,764	137	95.14%	
39	Calvert Memorial	1120	120	$117,602,616	$17,895,499	15.22%	$6,765,631	$11,129,868	9.46%	$7,100,039	137	95.14%	
55	Laurel Regional	739	310	$96,874,600	$18,126,493	18.71%	$5,774,427	$12,352,066	12.75%	$7,918,100	133	92.36%	
13	Bon Secours	804	13,263	$120,519,715	$23,849,284	19.79%	$9,916,345	$13,932,939	11.56%	$10,867,591	137	95.14%	
30	Chester River	360	0	$55,250,000	$11,431,252	20.69%	$3,967,592	$7,463,660	13.51%	$5,457,747	139	96.53%	
3	Prince George's	1893	310	$203,825,100	$53,619,510	26.31%	$24,783,262	$28,836,248	14.15%	$24,104,900	133	92.36%	
	Totals	**96,655**	**68,594**	**$13,532,154,004**	**$1,378,301,930**	**10.19%**	**$726,615,113**	**$651,686,817**	**4.82%**	**$487,132,406**			
											139	**96.53%**	**median**
	Averages	**2,101**	**1,491**								**137**	**95.05%**	**average**

Attachment III – FY 2012 Charity Care Funding

Hospital Name	Charity Care Amount in Rates
Anne Arundel General Hospital	$5,206,067
Atlantic General Hospital	$2,264,700
Baltimore Washington Medical Center	$16503446
Bon Secours Hospital	$9795025
Calvert Memorial Hospital	$6664934
Carroll County General Hospital	$2746949
Chester River Hospital Center	$3912152
Civista Medical Center	$1181238
Doctors Community Hospital	$2829144
Fort Washington Medical Center	$757342
Franklin Square Hospital	$10797365
Frederick Memorial Hospital	$6490078
Garrett County Memorial Hospital	$1604497
GBMC	$5213991
Good Samaritan Hospital	$5999510
Harbor Hospital Center	$6471202
Holy Cross Hospital of Silver Spring	$15044747
Howard County General Hospital	$5609577
JH Bayview Med. Center	$20745506
Johns Hopkins Hospital	$43890516
Kernan	$3140091
Laurel Regional Hospital	$5671640
Maryland General Hospital	$13947538
McCready Foundation, Inc.	$693472
Mercy Medical Center, Inc.	$13390926
Montgomery General Hospital	$5305444
Northwest Hospital Center, Inc.	$3060288
Peninsula Regional Medical Center	$9437294
Prince Georges Hospital	$20958375
Shady Grove Adventist Hospital	$8201074
Shore Health - Easton	$8247229
Shore Health-Dorchester General Hospital	$3622344
Sinai Hospital	$15601781
Southern Maryland Hospital	$2570082
St. Agnes Hospital	$17112323
St. Joseph Hospital	$3977318
St. Mary's Hospital	$4846542
Suburban Hospital	$4178750
UCH - Harford Memorial Hospital	$2316181
UCH - Upper Chesapeake Medical Center	$4533271
Union Hospital of Cecil County	$2389187
Union Memorial Hospital	$10343262
University of Maryland	$82640596
Washington Adventist Hospital	$3430042
Meritus Medical Center	$10280147
Western Maryland Regional Medical Center	$8385701
Total	$442,008,884

Attachment IV - FY 2012 DME Funding

Hospital Name	DME Amount in Rates
Anne Arundel	0
Atlantic General	0
Baltimore Washington	$422,195
Bon Secours	0
Calvert Memorial	0
Carroll Hospital	0
Chester River	0
Civista	0
Doctors	0
Fort Washington	0
Franklin Square	$7,881,364
Frederick Memorial	0
Garrett County	0
GBMC	$5,100,873
Good Samaritan	$5,293,171
Harbor Hospital	$5,003,909
Holy Cross	$2,305,891
Howard County	0
JH Bayview	$20,845,900
Johns Hopkins	$97,729,397
Kernan	$3,487,392
Laurel Regional	0
Maryland General	$4,510,915
McCready	0
Mercy	$4,668,533
Meritus Medical Center	0
Montgomery General	0
Northwest	0
Peninsula	0
Prince George's	$3,573,290
Shady Grove	0
Shore Health - Easton	0
Shore Health -Dorchester	0
Sinai	$14,750,170
Southern Maryland	0
St Agnes	$6,533,721
St Joseph	0
St Mary's	0
Suburban	$133,905
UCH-Harford	0
UCH-Upper Chesapeake	0
Union Cecil County	0
Union Memorial	$11,630,868
University of Maryland	$78,475,050
Washington Adventist	0
Western Maryland Regional Medical Center	0
Total	$272,346,544

Attachment V - FY 2012 Nurse Support I Funding

Hospital Name	NSP I Amount in Rates
Anne Arundel	$415,890
Atlantic General	$80,500
Baltimore Washington	$320,000
Bon Secours	$121,320
Calvert Memorial	$100,697
Carroll Hospital	$202,238
Chester River	$55,440
Civista	$111,481
Doctors	$196,074
Fort Washington	$44,747
Franklin Square	$422,965
Frederick Memorial	$282,475
Garrett County	$32,853
GBMC	$412,551
Good Samaritan	$294,819
Harbor Hospital	$115,642
Holy Cross	$411,325
Howard County	$130,590
JH Bayview	$518,108
Johns Hopkins	$1,709,103
Kernan	$101,537
Laurel Regional	$102,787
Maryland General	$178,831
McCready	0
Mercy	$349,266
Meritus Medical Center	$234,800
Montgomery General	$148,815
Northwest	$214,481
Peninsula	$50,000
Prince George's	$251,597
Shady Grove	$335,000
Shore Health - Easton	$160,769
Shore Health -Dorchester	$51,961
Sinai	$619,723
Southern Maryland	$223,251
St Agnes	$357,504
St Joseph	$333,978
St Mary's	$125,978
Suburban	$234,114
UCH-Harford	$83,045
UCH-Upper Chesapeake	$166,089
Union Cecil County	$126,899
Union Memorial	$399,909
University of Maryland	$1,013,735
Washington Adventist	$265,356
Western Maryland Regional Medical Center	$151,442
Total	$12,259,686

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

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Chairman

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Acting Executive Director

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Principal Deputy Director
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Hospital Rate Setting

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

TO: Commissioners

FROM: Legal Department

DATE: July 3, 2013

RE: Hearing and Meeting Schedule

Public Session:

August 7, 2013 1:00 p.m., 4160 Patterson Avenue, HSCRC Conference Room

September 4, 2013 1:00 p.m., 4160 Patterson Avenue, HSCRC Conference Room

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

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

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