

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE



John M. Colmers
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Thomas R. Mullen

Donna Kinzer
Acting Executive Director

Stephen Ports
Principal Deputy Director
Policy and Operations

Gerard J. Schmith
Deputy Director
Hospital Rate Setting

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

HEALTH SERVICES COST REVIEW COMMISSION

4160 Patterson Avenue, Baltimore, Maryland 21215

Phone: 410-764-2605 · Fax: 410-358-6217

Toll Free: 1-888-287-3229

hsrc.maryland.gov

**500th MEETING OF THE HEALTH SERVICES COST REVIEW COMMISSION
September 4, 2013**

EXECUTIVE SESSION

12:00 p.m.

1. Waiver Update
2. Personnel Matters

PUBLIC SESSION

****** Post-meeting Documents ******

1. Review of the Minutes from the Executive Sessions and Public Meeting Minutes from July 10, 2013, and the Executive Sessions on July 18, 2013 and August 7, 2013

2. Executive Director's Report

3. Docket Status – Cases Closed

2210A – Johns Hopkins Health System
2212A – Johns Hopkins Health System
2213A – University of Maryland Medical Center
2214A – University of Maryland Medical Center
2216A – Johns Hopkins Health System

4. Docket Status – Cases Open

2208R – Southern Maryland Hospital Center
2215R – Upper Chesapeake Medical Center - Approved
2217A – Johns Hopkins Health System - Approved
2218A – Johns Hopkins Health System - Approved
2219A – MedStar Health - Approved
2220N – University of Maryland Medical Center
2221A – Johns Hopkins Health System - Approved
2222A – MedStar Health - Approved
2223N – Atlantic General Hospital - Approved
2224A – Johns Hopkins Health System
2225A – Maryland Physicians Care

2226A – Johns Hopkins Health System
2227A – MedStar Health

5. **Final Recommendation for the Expansion of Required Health Information Exchange Data to Support Population-based Methodologies - Approved**
6. **Final Recommendation Regarding Medicare’s Two Midnight Rule Effective October 1, 2013 - Approved**
7. **Draft Recommendation on Monthly Submission of Case Mix data**
8. **Confidential Data Extension Request - Approved**
9. **Hearing and Meeting Schedule**

EXECUTIVE SESSION
Following Public Session

1. **Administrative Functions and Contractual Needs Related to Preparing for Alternative Waiver Model**

**Executive Session Minutes
Of the
Health Services Cost Review Commission**

July 10, 2013

Upon motion made, Chairman Colmers called the meeting to order at 12:07 p.m.

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

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

Donna Kinzer, Steve Ports, and Dennis Phelps attended representing staff.

Also attending were Stan Lustman and Leslie Schulman Commission counsel and Alice Burton Commission consultant,.

Item One

The Commission heard from Tom Trzcinski and Mark Higdon representing the Johns Hopkins Health System concerning its proposal to sell \$49 million of bonds to finance two projects on the Johns Hopkins Bayview Medical Center's campus

After discussion lead by Dr. Wong, the Commission voted to approve the Comfort Order request of the System, ratification of the vote to take place in the public session. Chairman Colmers did not participate in the discussion and recused himself from the vote.

Item Two

The Chairman updated the Commission on various waiver issues and discussions with the Centers for Medicare and Medicaid.

The Acting Executive Director presented a proposed strategy for stakeholder engagement in implementation planning and preparation for the modernized waiver.

Commissioner Mullen presented a draft proposal for implementation guidelines in support of the new all-payer reimbursement system produced by the Hospital Advisory Group.

The Executive Session was adjourned at 1:35 p.m.

MINUTES OF THE
499th MEETING OF THE
HEALTH SERVICES COST REVIEW COMMISSION

July 10, 2013

Chairman John Colmers called the meeting to order at 1:37 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.

COMFORT ORDER – JOHNS HOPKINS HEALTH SYSTEM

The Commission voted unanimously to ratify the vote to approve the Comfort Order for the Johns Hopkins Health System approved in Executive Session.

REPORT OF THE JULY 10th 2013 EXECUTIVE SESSION

Dennis Phelps, Associate Director-Audit & Compliance, summarized the minutes of the July 10, 2013 Executive Session.

ITEM I
REVIEW OF THE MINUTES OF THE JUNE 5, 2013 EXECUTIVE SESSION AND
PUBLIC MEETING

The Commission voted unanimously to approve the minutes of the June 5, 2013 Executive Session and Public Meeting.

ITEM II
EXECUTIVE DIRECTOR'S REPORT

Donna Kinzer, Acting Executive Director, reported that Monitoring Maryland Performance (MMP) indicated that the rate of growth in charge per case (CPC) increased by 1.88% for the month of May 2013 from the month of May 2012. For the twelve months ending May 2013, CPC increased 1.69% from the twelve months ending May 2012; inpatient revenue decreased 1.87%; the number of inpatient cases declined by 3.68%; outpatient revenue increased 10.91%; total gross revenue increased 2.85%. In addition, for the fiscal year-to-date May 2013 versus May 2012, total gross revenue increased 2.64%.

Ms. Kinzer stated that for the fiscal year-to-date ending May 2013, average operating profit margin for acute care hospitals was 0.72%, and the total profit margin was 3.61%.

Ms. Kinzer reported that discussions continue with the Centers for Medicare and Medicaid Innovation on the State's Model Demonstration proposal.

ITEM III
DOCKET STATUS CASES CLOSED

2209A – University of Maryland Medical Center 2211A – Johns Hopkins Health System

ITEM IV
DOCKET STATUS CASES OPEN

Johns Hopkins Health System – 2210A

Johns Hopkins Health System filed an application with the HSCRC on May 22, 2013 on behalf of Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center for an alternative method of rate determination. The System requested approval from the HSCRC to participate 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.

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 July 1, 2013, and 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 the discussion and the vote.

Johns Hopkins Health System – 2212A

On May 30, 2013, the Johns Hopkins Health 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 requested that the Commission approve the arrangement for one year effective July 1, 2013.

The staff recommended that the Commission approve the Hospitals' application for an alternative method of rate determination for cardiovascular services for one year beginning July 1, 2013, and 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 the discussion and the vote.

University of Maryland Medical Center – 2213A

University of Maryland Medical Center ("Hospital") filed an application with the HSCRC on June 11, 2013 for an alternative method of rate determination. The Hospital requested 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.

Based on the Hospital's favorable performance, staff recommended 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, and that the approval be contingent upon the execution of the standard Memorandum of Understanding.

The Commission voted unanimously to approve staff's recommendation.

University of Maryland Medical Center – 2214A

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 for solid organ and blood and bone marrow transplant services for a period of one year beginning August 23, 2013.

The staff recommended 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, and 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 – 2216A

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. 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 Blue Cross Blue Shield Blue Distinction Centers for Transplants 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 for a one year period commencing August 1, 2013, and 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 the discussion and the vote.

ITEM V
FINAL RECOMMENDATIONS ON FY 2014 UPDATE FACTOR FOR PSYCHIATRIC AND SPECIALTY HOSPITALS

At its June 5th public meeting, the Commission approved an update factor of 1.65% for acute hospitals only and directed staff to return at the July 10th meeting with a final recommendation for an update factor for the Psychiatric and other Specialty hospitals. Dennis Phelps, Associate Director-Audit & Compliance, presented staff's recommendation for the update factor for psychiatric and specialty hospitals (see, "Update Factor for FY 2014 for Psychiatric and Specialty Hospitals" on the HSCRC website).

Mr. Phelps stated that staff recommended an update factor of 1.8% for FY 2014 for the three psychiatric hospitals under the Commission's jurisdiction. In addition, staff recommended an update factor of 1.65% as previously recommended for acute hospitals for the Specialty hospitals and for the three Freestanding Emergency facilities.

The Commission voted unanimously to approve staff's recommendation.

ITEM VI
UPDATE ON MATCHING OF CHESAPEAKE REGIONAL INFORMATION SYSTEM FOR OUR PATIENTS (CRISP) AND HSCRC INPATIENT DATA

Claudine Williams, Associate Director- Policy Analysis and Research, introduced Scott Afzal, Health Information Exchange Director of CRISP. Mr. Afzal presented an update and progress report on CRISP. Mr. Afzal stated that the core object of the CRISP and HSCRC combined efforts is to accurately link a CRISP produced unique patient identifier to existing HSCRC inpatient tape data to enable inter-hospital analysis. CRISP receives real-time encounter data, i.e. facility, medical record number, etc. According to Mr. Afzal, CRISP is able to match the CRISP ID number and the HSCRC record 99.8% of the time. Most hospitals are receiving 30-day inter-hospital repeat admission reports monthly.

Mr. Afzal stated that the next steps for CRISP were: 1) to expand the data receive from hospital

to include all outpatient visits; 2) to link CRISP and HSCRC data to produce comprehensive reports to hospitals regarding not only readmissions but also utilization patterns of their patients; and 3) to support HSCRC population-based methodologies through more comprehensive analytics.

ITEM VII
DRAFT RECOMMENDATION FOR THE EXPANSION OF REQUIRED HEALTH INFORMATION EXCHANGE DATA TO SUPPORT POPULATION-BASED METHODOLOGIES

Ms. Williams presented a draft recommendation for Expansion of the Required Health Information Data to Support Population-based Methodologies (see, “Expansion of the Required Health Information Data to Support Population-based Methodologies” on the HSCRC website).

Ms. Williams stated that because of the movement to population-based strategies that require complete historical data, staff proposes that the Commission require hospitals to submit data fields for all outpatient visits by December 1, 2013 through the existing connectivity with CRISP. In addition, staff proposed that hospitals also be required to provide outpatient data for CY 2012 in a manner and in a time frame to be determined.

Tracy LaValle, Assistant vice President-Financial Policy and Operations of the Maryland Hospital Association, voiced support for collecting the current outpatient data on-line; however, she expressed concern about the need for and the ability of hospitals to submit historical outpatient data.

Since this is a draft recommendation, no Commission action was required.

ITEM VIII
REPORT ON FINAL YEAR OF FUNDING THROUGH THE HSCRC FOR CRISP

Dianne Feeney, Associate Director-Quality Initiative, presented the HSCRC funding and status report for CRISP (see “Maryland’s Statewide Health Information Exchange, the Chesapeake Regional Information System for our patients: HSCRC Funding and Status Report” on the HSCRC website). Ms. Feeney noted that the HSCRC approved funding of up to \$10 million for CRISP to initiate the development of a state-wide health information network in August of 2009. In 2011, CRISP became the first health information exchange in the nation to connect to all acute hospitals in a state and to receive admission, discharge, and transfer data, as well as patient demographic data. This enabled CRISP to produce a unique patient identifier number.

Ms. Feeney reported that for FY 2014, the last year of HSCRC-approved funding, CRISP will receive \$1,166,278. According to Ms. Feeney, CRISP has worked successfully to secure additional funding sources; however, moving forward HSCRC and Maryland Health Care Commission staff will continue to work with CRISP to develop key deliverables and review

milestones in current projects that may be the basis for future funding requests. Ms. Feeney noted that HSCRC staff would present a draft recommendation for possible future funding in the fall of 2013.

Commissioner Keane asked whether CRISP was going to expand its data base to include non-hospital outpatient providers such as free standing imaging and surgery centers, Federally Qualified Health Centers, and physicians.

Mr. Afzal stated that CRISP was working on adding these kinds of providers, but that it would take time.

ITEM IX **ANNUAL COMMUNITY BENEFIT REPORT**

Steve Ports, Principal Deputy Director-Policy and Operations, provided background and summarized the ninth annual Maryland Hospital Community Benefits Report (CBR) (see “Maryland Hospital Community Benefits Report FY 2012” on the HSCRC’s website).

According to Mr. Ports, the FY CBR indicated that hospitals: 1) reported a total of \$1.4 billion in community benefits for FY 2012 (compared to \$1.2 billion in FY 2011); 2) provided an average of 10.06% of total operating expenses in community benefits (compared to 9.23% in FY 2011); 3) provided net charity care of \$45 million; and 4) provided net community care of \$651.6 million or 4.82% of hospitals’ net operating expenses (up from \$580.4 million and 4.45% of hospitals’ net operating expenses in FY 2011).

Mr. Ports reported that hospitals’ Community Benefit Narrative Reports showed much improvement in FY 2012. Of the forty-five hospitals evaluated, the average score was 137 out of a possible 145 points. Four hospitals earned 100%, and only one scored below 80%.

Mr. Ports noted that the Affordable Care Act requires hospital to perform a Community Health Needs Assessment and to adopt an implementation plan to meet the needs identified for the first time in FY 2013. According to Mr. Ports, the Community Benefits Narrative Reports should improve in light of the Needs Assessment process.

ITEM X **LEGAL REPORT**

Stan Lustman, Commission Counsel, presented a Board of Physicians regulation for joint promulgation by the Secretary of Health and Mental Hygiene, the Health Services Cost Review Commission, the Maryland Health Care Commission, and the Maryland Board of Physicians.

Regulations

Proposed

Disclosure of Records for State Health Agencies – COMAR 10.37.32.19

The purpose of the joint regulation is to adopt new regulations for the efficient and secure transfer of information contained in a record maintained by the Board of Physicians, which may indicate that an investigation of an entity regulated by the Office of Health Care Quality, Maryland Health Care Commission, or the Health Services Cost Review Commission may be appropriate.

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

HEARING AND MEETING SCHEDULE

August 7, 2013	Time to be determined, 4160 Patterson Avenue, HSCRC Conference Room
September 4, 2013	Time to be determined, 4160 Patterson Avenue, HSCRC Conference Room

There being no further business, the meeting was adjourned at 3:17 p.m.

Executive Session
Of the
Health Services Cost Review Commission

MINUTES

July 18, 2013

Upon motion made, Chairman Colmers called the phone conference meeting to order at 12:30 p.m. The meeting was held under the authority of § 10-508 of the State Government Article. Participating, in addition to Chairman Colmers, were Commissioners Bone, Jencks, Keane, Loftus, Mullen and Wong. DHMH Secretary Joshua Sharfstein also participated.

Participating in the phone conference representing HSCRC staff were: Donna Kinzer, Steve Ports, Ellen Englert and Dennis Phelps. Commission Counsel Stan Lustman and Leslie Schulman also participated.

ITEM

Following introductory remarks by Secretary Sharfstein, the Chairman provided an update on the State's application for a new Waiver Demonstration Project.

Upon Motion made, the Executive Session phone conference was adjourned at 1:26 p.m.

EXECUTIVE SESSION – AUGUST 7, 2013

Upon motion made, Chairman John Colmers called the Executive Session to order at 12:07 p.m. In Attendance, in addition to Chairman Colmers, were Commissioners Bone, Jencks, Keane, Mullen, and Wong. Commissioner Loftus participated by telephone. Also in attendance representing Staff were: Donna Kinzer, Acting Executive Director, Staff consultant Alice Burton, and Staff persons Sule Calikoglu, Ellen Englert, Dennis Phelps, and Steve Ports. Leslie Schulman and Stan Lustman attended as Commission Counsel.

Following opening remarks by the Chairman commending the work of the Acting Executive Director, Donna Kinzer, the Commission was briefed by the Chairman on the status of the new waiver proposal. Ms. Kinzer described the basic differences in approach under a population based and patient-centered payment system, if approved by CMS, versus the current rate setting system components. Ms. Kinzer also presented a draft framework, contingent on CMS approval of a new all-payer model, for public engagement and implementation, including the establishment of: 1) a Senior Advisory Council to provide broad input on the guiding principles for the HSCRC to consider in implementation of a new Payment Systems design; and 2) specific work groups to provide structured input to the HSCRC on key implementation issues. The Commission reiterated its desire for transparency and consensus building. Finally, Ms. Kinzer described a potential implementation timeline as well as the staff process for transitioning to a January 1 implementation date.

Upon motion made, the Executive Session was adjourned at 2:03 p.m.

EXECUTIVE DIRECTOR'S REPORT

SEPTEMBER 4, 2013

Monitoring Maryland Performance

For Year Ended June 30, 2013

- Charge per Case increased 2.04%
- Cases (admissions + new born) decreased 3.58%
- Inpatient revenue decreased 1.61%
- Outpatient revenue increased 9.13%
- Total gross revenue increased 2.39%

Financial Condition

Preliminary year end data are available for profits for the year ended June 30, 2013. The average operating profits for all acute care hospitals was 0.72 percent. The total profit margin for this year is 3.39 percent. The median hospital had an operating profit of 1.10 percent, with a distribution as follows:

- 25th percentile at -1.32 percent
- 75th percentile at 4.76 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 influenced by potential transitional issues and losses at University of Maryland St. Joseph's Medical Center (UMSJMC). When excluding UMSJMC, the financial results for the year ended June 30, 2013 were an operating profit margin of 1.12 percent and a total profit margin of 3.86 percent.

New Monthly Reporting Requirements

HSCRC staff are preparing new monthly reporting requirements to enable performance monitoring under population-based and global rate setting approaches, as well as providing more timely and accurate waiver monitoring. We will present a staff recommendation regarding monthly case mix data today. At the October meeting, we will present a staff recommendation for revised monthly financial and statistical reporting. We will request that hospitals provide historical monthly totals for these reports, in light of the need to look at year over year trends. Hospitals will need to program these reports, so we will be discussing and distributing draft formats within the next week to enable hospitals to provide input and begin to work on revised reporting formats. We will also reach out to payers to obtain their input in these new monthly formats. In the meantime, HSCRC will be contracting with a vendor to update the monthly reporting tool we currently employ, so that this reporting can continue to be an automated process.

New Billing Requirements for Medicare "Present on Admission" Indicator and Attention to Coding on Medicare Bills

CMS has instituted new billing requirements for Medicare in Maryland effective October 1. Hospitals will be required to include the Present on Admission (POA) indicator for diagnoses and conditions to allow a determination of whether a condition was hospital acquired. This coding is very important because comparative quality is judged in part based on this indicator. Medicare's expanded value based purchasing approach increasingly relies on coding in the Medicare claim as the basis for value comparisons. Historically, Maryland hospitals have not had to pay as much attention to the depth of coding at the point of discharge due to claims lags with HSCRC data submissions. Nor have they had to submit POA indicators. HSCRC staff urges hospitals to pay close attention to depth of coding and POA indicators for Medicare beginning October 1. These items will form the basis for both quality and cost comparisons for Medicare in 2014 and beyond. Hospitals in Maryland and the success of the system will be judged based on the accuracy of this information. HSCRC staff expect to work with Maryland Hospital Association to provide training and guidance on this topic.

Charge per Case Update

During the past several months, HSCRC approved several case mix policies including a policy to reincorporate 0 and 1 day stays into the Charge Per Case(CPC) methodology as well as instituting low outliers. However, Medicare is implementing a 2 midnight rule that will result in most 0 and 1 day stays being classified as outpatient for Medicare. In light of the continuing changes, staff proposes to look at two options:

1. Incorporate 1 day stays and similar outpatient observation and surgery cases into the CPC, possibly in a severity level 0 to avoid affecting the weights of the other inpatient cases. Use this data to calculate updated CPC targets and Admission Readmission Revenue (ARR) targets. While this is a preferred approach, it has technical challenges and may not be ready for implementation on January 1, 2014.
2. A second approach is to maintain the same case mix method currently in place, with just the usual update process (including transition to the APR-DRG grouper 30). This would not reincorporate 0-1 day stays or outpatient cases. Staff would propose an adjustment to the ARR gain or loss based on the change in observation cases that would otherwise be counted as readmissions (two or more midnights).

Staff plans to report progress and provide a staff recommendation on these possible changes at the November HSCRC meeting. In the meantime, staff will be reaching out to providers and payers for their input on these changes.

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. In the near future, HSCRC staff expects to release plans for work groups, make a call for white papers of selected technical issues, and conduct a public process to gain input as it evaluates approaches and requirements for new models of care and payments.

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

AS OF AUGUST 27, 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	9/4/2013	10/3/2013	PEDS	CK	OPEN
2215R	Upper Chesapeake Medical Center	6/14/2013	9/4/2013	11/12/2013	RAT	CK	OPEN
2217A	Johns Hopkins Health System	7/24/2013	N/A	N/A	ARM	DNP	OPEN
2218A	Johns Hopkins Health System	7/24/2013	N/A	N/A	ARM	DNP	OPEN
2219A	MedStar Health	7/26/2013	N/A	N/A	ARM	DNP	OPEN
2220N	University of Maryland Medical Center	8/1/2013	9/4/2013	12/30/2013	TRAUMA	DNP	OPEN
2221A	Johns Hopkins Health System	8/1/2013	N/A	N/A	ARM	DNP	OPEN
2222A	MedStar Health	8/1/2013	N/A	N/A	ARM	DNP	OPEN
2223N	Atlantic General Hospital	8/2/2013	9/4/2013	12/30/2013	LIT	DNP	OPEN
2224A	Johns Hopkins Health System	8/14/2013	N/A	N/A	ARM	SP	OPEN
2225A	Maryland Physicians Care	8/22/2013	N/A	N/A	ARM	SP	OPEN
2226A	Johns Hopkins Health System	8/27/2013	N/A	N/A	ARM	DNP	OPEN
2227A	MedStar Health	8/27/2013	N/A	N/A	ARM	SP	OPEN

NONE

PROCEEDINGS REQUIRING COMMISSION ACTION - NOT ON OPEN DOCKET

IN RE: THE PARTIAL RATE	*	BEFORE THE HEALTH SERVICES
APPLICATION OF THE	*	COST REVIEW COMMISSION
UPPER CHESAPEAKE	*	DOCKET: 2013
MEDICAL CENTER	*	FOLIO: 2025
BEL AIR, MARYLAND	*	PROCEEDING: 2215R

Staff Recommendation

September 4, 2013

Introduction

On June 14, 2013, Upper Chesapeake Medical Center (the "Hospital") submitted a partial rate application to the Commission for a rate for Radiation Therapy (RAT) services to be provided to both inpatients and outpatients. This new rate would replace its currently approved rebundled RAT rate. A rebundled rate is approved by the Commission when a hospital provides certain non-physician services to inpatients through a third-party contractor off-site. By approving a rebundled rate, the Commission makes it possible for a hospital to bill for services provided off site, as required by Medicare. In this case, however, as of September 1, 2013, the Hospital will be providing RAT services on-site to both inpatients and outpatients. The Hospital requests that the RAT rate be set at the lower of a rate based on its projected costs to provide RAT services or the statewide median and be effective September 1, 2013.

Staff Evaluation

To determine if the Hospital's RAT rate should be set at the statewide median or at a rate based on its own cost experience, the staff requested that the Hospital submit to the Commission its RAT cost and statistical data projections for FY 2014. Based on information received, it was determined that the RAT rate based on the Hospital's projected data would be \$28.11 per RVU, while the statewide median rate for RAT services is \$28.68 per RVU.

Recommendation

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

1. That an RAT rate of \$28.11 per RVU be approved effective September 1, 2013;
2. That no change be made to the Hospital's Charge per Episode standard for RAT services;
3. That the RAT rate not be rate realigned until a full year's cost experience data have been reported to the Commission.

**IN RE: THE APPLICATION FOR
ALTERNATIVE METHOD OF RATE
DETERMINATION
JOHNS HOPKINS HEALTH
SYSTEM
BALTIMORE, MARYLAND**

*** BEFORE THE MARYLAND HEALTH
* SERVICES COST REVIEW
* COMMISSION
* DOCKET: 2013
* FOLIO: 2027
* PROCEEDING: 2217A**

**Staff Recommendation
September 4, 2013**

I. INTRODUCTION

Johns Hopkins Health System (“System”) filed an application with the HSCRC on July 24, 2013 on behalf of its member hospitals (the “Hospitals”) for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System requests approval from the HSCRC to add pediatric and adult live donor liver transplants to the global rate arrangement for solid organ and bone marrow transplants services with Cigna Health Corporation approved under proceeding 2194A at the Commission’s December 5, 2012 public meeting. The System requested approval of the revised arrangement effective September 1, 2013 with an expiration date of December 31, 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 Hospitals and bear all risk relating to regulated services associated with the contract.

III. FEE DEVELOPMENT

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

IV. IDENTIFICATION AND ASSESSMENT OF RISK

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

V. STAFF EVALUATION

Staff found that the experience under this arrangement for the last year for solid organ and bone marrow transplants has been favorable. Staff also found that the rate for pediatric and adult live donor liver transplants was developed based on a format, i.e., historical hospital data for like cases, which has resulted in a favorable experience in other global rate arrangements.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' request to add pediatric and adult live donor liver transplants to the existing alternative method of rate determination for solid organ and bone marrow transplants effective September 1, 2013 and that the approval for the revised arrangement shall expire on December 31, 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
ALTERNATIVE METHOD OF RATE
DETERMINATION
JOHNS HOPKINS HEALTH
SYSTEM
BALTIMORE, MARYLAND**

*** BEFORE THE MARYLAND HEALTH
* SERVICES COST REVIEW
* COMMISSION
* DOCKET: 2013
* FOLIO: 2028
* PROCEEDING: 2218A**

Staff Recommendation

September 4, 2013

I. INTRODUCTION

Johns Hopkins Health System (“System”) filed a renewal application with the HSCRC on July 24, 2013 on behalf of the Johns Hopkins Bayview Medical Center (the “Hospital”) requesting approval from the HSCRC for continued participation in a capitation arrangement among the System, the Maryland Department of Health and Mental Hygiene (DHMH), and the Centers for Medicare and Medicaid Services (CMS). The Hospital, doing business as Hopkins Elder Plus (“HEP”), serves as a provider in the federal “Program of All-inclusive Care for the Elderly” (“PACE”). Under this program, HEP provides services for a Medicare and Medicaid dually eligible population of frail elderly. The requested approval is for a period of one year effective September 1, 2013.

II. OVERVIEW OF APPLICATION

The parties to the contract include the System, DHMH, and CMS. The contract covers medical services provided to the PACE population. The assumptions for enrollment, utilization, and unit costs were developed on the basis of historical HEP experience for the PACE population as previously reviewed by an actuarial consultant. The System will assume the risks under the agreement, and all Maryland hospital services will be paid based on HSCRC rates.

III. STAFF EVALUATION

Staff found that the experience under this arrangement for FY 2012 was favorable.

III. STAFF RECOMMENDATION

Staff recommends that the Commission approve the Hospital’s renewal application for an alternative method of rate determination for one year beginning September 1, 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 formalizes the understanding between the Commission and the Hospital, and

includes 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 also stipulates that operating losses under the contract cannot be used to justify future requests for rate increases.

**IN RE: THE APPLICATION FOR
ALTERNATIVE METHOD OF RATE
DETERMINATION
MEDSTAR HEALTH

BALTIMORE, MARYLAND**

*** BEFORE THE MARYLAND HEALTH
* SERVICES COST REVIEW
* COMMISSION
* DOCKET: 2013
* FOLIO: 2909
* PROCEEDING: 2219A**

Staff Recommendation

September 4, 2013

I. INTRODUCTION

MedStar Health filed an application with the HSCRC on July 26, 2013 on behalf of Union Memorial Hospital and Good Samaritan Hospital (the “Hospitals”) for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. Medstar Health requests approval from the HSCRC for continued participation in a global rate arrangement for cardiovascular services with the Kaiser Foundation Health Plan of the Mid-Atlantic, Inc. for one year beginning October 1, 2013.

II. OVERVIEW OF APPLICATION

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

III. FEE DEVELOPMENT

The hospital portion of the global rates is based on hospital experience for similar cases. The remainder of the global rate is comprised of physician service costs.

IV. IDENTIFICATION AND ASSESSMENT OF RISK

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

V. STAFF EVALUATION

The staff reviewed the results of last year’s experience under this arrangement and found that they were favorable. Staff believes that the Hospitals can continue to achieve favorable experience under this arrangement.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' request for continued participation in the alternative method of rate determination for cardiovascular services for a one year period commencing October 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, 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
ALTERNATIVE METHOD OF RATE**

*** BEFORE THE MARYLAND HEALTH
* SERVICES COST REVIEW**

DETERMINATION

*** COMMISSION**

**JOHNS HOPKINS HEALTH
SYSTEM**

*** DOCKET: 2013**

BALTIMORE, MARYLAND

*** FOLIO: 2031
* PROCEEDING: 2221A**

Staff Recommendation

September 4, 2013

I. INTRODUCTION

On August 1, 2013, Johns Hopkins Health System (“System”) filed an alternative rate application on behalf of its member hospitals, Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, and Howard County General Hospital (the “Hospitals”) requesting approval from the HSCRC to continue to participate in a global rate arrangement with the Canadian Medical Network for cardiovascular procedures, kidney transplant services, and bone marrow transplants. The Hospitals request that the Commission approve the arrangement for one year beginning September 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 Hospitals and bear all risk relating to regulated services associated with the contract.

III. FEE DEVELOPMENT

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

IV. IDENTIFICATION AND ASSESSMENT OF RISK

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

V. STAFF EVALUATION

Staff finds that the actual experience for cardiovascular services, kidney transplants, and bone marrow transplants under the arrangement for the last year has been favorable.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for cardiovascular procedures, kidney transplant services, and bone marrow transplant services for one year beginning September 1, 2013. The Hospitals must file a renewal application annually for continued participation. Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff

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

**IN RE: THE APPLICATION FOR
ALTERNATIVE METHOD OF RATE
DETERMINATION
MEDSTAR HEALTH

BALTIMORE, MARYLAND**

*** BEFORE THE MARYLAND HEALTH
* SERVICES COST REVIEW
* COMMISSION
* DOCKET: 2013
* FOLIO: 2032
* PROCEEDING: 2222A**

**Staff Recommendation
September 4, 2013**

I. INTRODUCTION

MedStar Health filed an application with the HSCRC on August 1, 2013 on behalf of Union Memorial Hospital and Good Samaritan Hospital (the "Hospitals") to continue to participate in an alternative method of rate determination, pursuant to COMAR 10.37.10.06. MedStar Health requests approval from the HSCRC for continued participation in a global rate arrangement for orthopedic services with MAMSI for a one year period beginning September 1, 2013.

II. OVERVIEW OF APPLICATION

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

III. FEE DEVELOPMENT

The hospital portion of the global rates was developed by calculating the mean historical charges for 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 HRMI for all contracted and covered services. HRMI is responsible for billing the payer, collecting payments, disbursing payments to the Hospitals at their full HSCRC approved rates, and reimbursing the physicians. The Hospitals contend that the arrangement between HRMI and the Hospitals holds the Hospitals harmless from any shortfalls in payment from the global price contract.

V. STAFF EVALUATION

The staff reviewed the experience under this arrangement for the last year and found that it was favorable. The staff believes that the Hospitals can continue to achieve a favorable experience under this arrangement.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' request for continued participation in the alternative method of rate determination for orthopedic services, for a one year period, commencing September 1, 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 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 PARTIAL RATE	*	BEFORE THE HEALTH SERVICES
APPLICATION OF	*	COST REVIEW COMMISSION
ATLANTIC GENERAL	*	DOCKET: 2013
HOSPITAL	*	FOLIO: 2033
BERLIN, MARYLAND	*	PROCEEDING: 2223N

Staff Recommendation

September 4, 2013

Introduction

On August 2, 2013, Atlantic General Hospital (the "Hospital") submitted a partial rate application to the Commission requesting a rate for Lithotripsy (LIT) services. The Hospital requests that the LIT rate be set at the lower of a rate based on its projected costs to provide LIT services or the statewide median and be effective August 1, 2013.

Staff Evaluation

To determine if the Hospital's LIT rate should be set at the statewide median or at a rate based on its own cost experience, the staff requested that the Hospital submit to the Commission all projected cost and statistical data for LIT services for FY2014. Based on information received, it was determined that the LIT rate based on the Hospital's projected data would be \$3,043.17 per procedure, while the statewide median rate for LIT services is \$3,039.29 per procedure.

Recommendation

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

1. That a LIT rate of \$3,039.29 per procedure be approved effective October 1, 2013;
2. That no change be made to the Hospital's Charge per Case standard for LIT services; and
3. That the LIT rate not be rate realigned until a full year's cost experience data have been reported to the Commission.

IN RE: THE ALTERNATIVE	*	BEFORE THE HEALTH	
RATE APPLICATION OF	*	SERVICES COST REVIEW	
THE JOHNS HOPKINS HEALTH	*	COMMISSION	
SYSTEM	*	DOCKET:	2013
	*	FOLIO:	2034
BALTIMORE, MARYLAND	*	PROCEEDING	2224A

Draft Recommendation

September 4, 2013

I. Introduction

On August 14, 2013 Johns Hopkins Health System (“JHHS,” or the “System”) filed an application for an Alternative Method of Rate Determination pursuant to COMAR 10.37.10.06 on behalf of Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, and Howard County General Hospital (the “Hospitals”). The System seeks renewal for the continued participation of Priority Partners, Inc. in the Medicaid Health Choice Program. Priority Partners, Inc. is the entity that assumes the risk under the contract. The Commission most recently approved this contract under proceeding 2178A for the period from January 1, 2013 through December 31, 2013. The Hospitals are requesting to renew this contract for a one-year period beginning January 1, 2014.

II. Background

Under the Medicaid Health Choice Program, Priority Partners, a provider-sponsored Managed Care Organization (“MCO”) sponsored by the Hospitals, is responsible for providing a comprehensive range of health care benefits to Medical Assistance enrollees. Priority Partners was created in 1996 as a joint venture between Johns Hopkins Health Care (JHHC) and the Maryland Community Health System (MCHS) to operate an MCO under the Health Choice Program. Johns Hopkins Health Care operates as the administrative arm of Priority Partners and receives a percentage of premiums to provide services such as claim adjudication and utilization management. MCHS oversees a network of Federally Qualified Health Clinics and provides member expertise in the provision of primary care services and assistance in the development of provider networks.

The application requests approval for the Hospitals to continue to provide inpatient and

outpatient hospital services, as well as certain non-hospital services, in return for a State-determined capitation payment. Priority Partners pays the Hospitals HSCRC-approved rates for hospital services used by its enrollees. The Hospitals supplied information on their most recent experience and their preliminary projected revenues and expenditures for the upcoming year based on the initial revised Medicaid capitation rates.

Priority Partners is a major participant in the Medicaid Health Choice program, providing managed care services to 26.4% of the State's MCO population.

III. Staff Review

This contract has been operating under the HSCRC's initial approval in proceeding 2178A. Staff reviewed the operating performance under the contract as well as the terms of the capitation pricing agreement. Staff has analyzed Priority Partner's financial history, net income projections for CY 2013, and projections for CY 2014. The statements provided by Priority Partners to staff represent both a "standalone" and "consolidated" view of Priority's operations. The consolidated picture reflects certain administrative revenues and expenses of Johns Hopkins Health Care. When other provider-based MCOs are evaluated for financial stability, their administrative costs relative to their MCO business are included as well; however, they are all included under one entity.

In recent years, the consolidated financial performance of Priority Partners has been favorable. The actual financial experience reported to staff for CY 2012 was positive, and is expected to remain positive in CY 2013 and CY 2014.

IV. Recommendation

Priority Partners has continued to achieve favorable financial performance in recent years. Based on past and projected performance, staff believes that the proposed renewal arrangement for Priority Partners is acceptable under Commission.

Therefore:

- 1) Staff recommends approval of this alternative rate application for a one-year period beginning January 1, 2014.**
- 2) Since sustained losses over an extended period of time may be construed as a loss contract necessitating termination of this arrangement, staff will continue to monitor financial performance in CY 2013, and the MCOs expected financial status into CY 2014. Therefore, staff recommends that Priority Partners report to Commission staff (on or before the September 2014 meeting of the Commission) on the actual CY 2013 experience, and preliminary CY 2014 financial performance (adjusted for seasonality) of the MCO, as well as projections for CY 2015.**
- 3) Consistent with its policy paper outlining a structure for review and evaluation of applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the continued adherence to the standard Memorandum of Understanding with the Hospitals for the approved contract. This document formalizes the understanding between the Commission and the Hospitals, and includes provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the managed care contract, quarterly and annual reporting, the 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 also stipulates that operating losses under managed care contracts may not be used to justify future requests for rate increases.

IN RE: THE ALTERNATIVE	*	BEFORE THE HEALTH
RATE APPLICATION OF	*	SERVICES COST REVIEW
MARYLAND GENERAL HOSPITAL	*	COMMISSION
SAINT AGNES HEALTH	*	DOCKET: 2013
WESTERN MARYLAND HEALTH SYSTEM	*	FOLIO: 2035
MERITUS HEALTH	*	PROCEEDING: 2225A

Draft Recommendation

September 4, 2013

I. Introduction

On August 19, 2013, Maryland General Hospital, Saint Agnes Health System, Western Maryland Health System, and Meritus Health (the "Hospitals") filed an application for an Alternative Method of Rate Determination pursuant to COMAR 10.37.10.06. The Hospitals seek renewal for the continued participation of Maryland Physicians Care ("MPC") in the Medicaid Health Choice Program. MPC is the entity that assumes the risk under this contract. The Commission most recently approved this contract under proceeding 2177A for the period January 1, 2013 through December 31, 2013. The Hospitals are requesting to renew this contract for one year beginning January 1, 2014.

II. Background

Under the Medicaid Health Choice Program, MPC, a Managed Care Organization ("MCO") sponsored by the Hospitals, is responsible for providing a comprehensive range of health care benefits to Medical Assistance enrollees. The application requests approval for the Hospitals to provide inpatient and outpatient hospital services as well as certain non-hospital services, in return for a State-determined capitation payment. Maryland Physicians Care pays the Hospitals HSCRC-approved rates for hospital services used by its enrollees. Maryland Physicians Care is a major participant in the Medicaid Health Choice program, and provides services on a statewide basis to about 20% of the total number of MCO enrollees in Maryland.

The Hospitals supplied information on their most recent experience and their preliminary projected revenues and expenditures for the upcoming year based on the revised Medicaid capitation rates.

III. Staff Review

This contract has been operating under previous HSCRC approval (Proceeding 2177A). Staff reviewed the operating performance under the contract as well as the terms of the capitation pricing agreement. Staff reviewed financial information and projections for CYs 2012 and 2013, and preliminary projections for CY 2014. In recent years, the financial performance of MPC has been favorable. The actual financial experience reported to staff for CY2012 was positive, and is expected to remain positive in CY 2013. However, the MCO projects continued favorable financial performance in CY 2014.

IV. Recommendation

MPC has continued to maintain consistent favorable performance in recent years. Based on past and projected performance, staff believes that the proposed renewal arrangement for MPC is acceptable under Commission.

Therefore:

- (1) Staff recommends approval of this alternative rate application for a one-year period beginning January 1, 2014.**
- (2) Since sustained losses over an extended period of time may be construed as a loss contract necessitating termination of this arrangement, staff will continue to monitor financial performance for CY 2013 and the MCOs expected financial status into CY 2014. Staff recommends that Maryland Physicians Care report to Commission staff (on or before the September 2014 meeting of the Commission) on the actual CY 2013 experience, preliminary CY 2014 financial performance (adjusted for seasonality) of the MCO, as well as projections for CY 2015.**

(3) Consistent with its policy paper outlining a structure for review and evaluation of applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the continued adherence to the standard Memorandum of Understanding with the Hospitals for the approved contract. This document formalizes the understanding between the Commission and the Hospitals, and includes provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the managed care contract, quarterly and annual reporting, the 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 also stipulates that operating losses under managed care contracts may not be used to justify future requests for rate increases.

IN RE: THE ALTERNATIVE	*	BEFORE THE HEALTH	
RATE APPLICATION OF	*	SERVICES COST REVIEW	
MEDSTAR HEALTH	*	COMMISSION	
SYSTEM	*	DOCKET:	2013
	*	FOLIO:	2037
COLUMBIA, MARYLAND	*	PROCEEDING:	2227A

Draft Recommendation

September 4, 2013

I. Introduction

On August 27, 2013, MedStar Health filed an application for an Alternative Method of Rate Determination pursuant to COMAR 10.37.10.06 on behalf of Franklin Square Hospital, Good Samaritan Hospital, Harbor Hospital, and Union Memorial Hospital (the "Hospitals"). MedStar Health seeks renewal for the continued participation of MedStar Family Choice ("MFC") in the Medicaid Health Choice Program. MedStar Family Choice is the MedStar entity that assumes the risk under this contract. The Commission most recently approved this contract under proceeding 2179A for the period from January 1, 2013 through December 31, 2013. The Hospitals are requesting to renew this contract for one year beginning January 1, 2014.

II. Background

Under the Medicaid Health Choice Program, MedStar Family Choice, a Managed Care Organization ("MCO") sponsored by the Hospitals, is responsible for providing a comprehensive range of health care benefits to Medical Assistance enrollees. The application requests approval for the Hospitals to provide inpatient and outpatient hospital services, as well as certain non-hospital services, in return for a State-determined capitation payment. MedStar Family Choice pays the Hospitals HSCRC-approved rates for hospital services used by its enrollees. MedStar Family Choice provides services to 4.1% of the total number of MCO enrollees in Maryland.

The Hospitals supplied information on their most recent experience and their preliminary projected revenues and expenditures for the upcoming year based on the Medicaid capitation rates.

III. Staff Review

This contract has been operating under previous HSCRC approval (proceeding 2179A).

Staff reviewed the operating performance under the contract as well as the terms of the capitation pricing agreement. Staff reviewed financial information and projections for CYs 2012 and 2013, and projections for CY 2014. In recent years, the financial performance of MFC has been favorable. The actual financial experience reported to staff for CY 2012 was positive, and is expected to remain positive in CY 2013. MFC is projecting continued favorable performance in CY 2014.

IV. Recommendation

MFC has continued to achieve favorable financial performance in recent years. Based on past performance, staff believes that the proposed renewal arrangement for MFC is acceptable under Commission policy.

Therefore:

- (1) Staff recommends approval of this alternative rate application for a one-year period beginning January 1, 2014.**
- (2) Since sustained losses may be construed as a loss contract necessitating termination of this arrangement, staff will continue to monitor financial performance to determine whether favorable financial performance is achieved in CY 2013, and expected to be sustained into CY 2014. Staff recommends that MedStar Family Choice report to Commission staff (on or before the September 2014 meeting of the Commission) on the actual CY 2013 experience and preliminary CY 2014 financial performance (adjusted for seasonality) of the MCO, as well as projections for CY 2014.**
- (3) Consistent with its policy paper outlining a structure for review and evaluation of**

applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the continued adherence to the standard Memorandum of Understanding with the Hospitals for the approved contract. This document formalizes the understanding between the Commission and the Hospitals, and includes provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the managed care contract, quarterly and annual reporting, the 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 also stipulates that operating losses under managed care contracts may not be used to justify future requests for rate increases.

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

FINAL STAFF RECOMMENDATION

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

September 4, 2013

These final recommendations were approved by the Commission at the September 4, 2013 Public Commission Meeting.

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 which 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, to accurately assess hospital utilization across care settings and hospitals. The staff is proposing to require all hospitals to submit to CRISP the 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
Phone Number	Yes ¹	

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 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 and CRISP are working on a process to link the Unique ID to the hospital reported data on a quarterly basis.

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 Historical 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 2 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. HSRC staff convened several meetings with CRISP in July and August to evaluate alternative methods.

Table 2: Required Data Fields for Creation of Unique IDs for Historical Data

Hospital Medicare Provider ID	Address Home, City
Medical Record Number (MRN)	Address Home, State
Enterprise / System Level Patient ID	Address Home, Zip code
Visit/Encounter ID (VID)	Address Home, Country (if foreign)
Admission (From)Timestamp	Address Work, Street
Discharge (Thru) Timestamp	Address Work, City
Name, Other	Address Work, State
Phone Number, Home	Address Work, Zip code
Phone Number, Work	Address Work, Country (if foreign)
Phone Number, Mobile	Gender
Address Home, Street	Social Security Number

6. Input from Hospital Industry

On August 13, 2013, HSCRC and CRISP staff convened a conference call with Chief Information Officers and other relevant hospital staff to discuss the process for submitting outpatient visit ADT messages to CRISP beginning in December 2013. Twenty-one hospitals were represented at the meeting. Most hospitals reported that they were already submitting outpatient data to the HIE, and that any expansion of that data feed would not be problematic. A few representatives indicated that their hospitals were going through major conversions that could delay implementation of OP submission to the HIE. HSCRC and CRISP will work with those hospitals to ensure timely submissions.

There was also discussion around submitting historical CY 2012 data to CRISP for EID creation. CRISP discussed two options for submitting retrospective patient demographic information in order to create a unique CRISP ID for that patient, thereby enabling the ability to link the unique ID to the outpatient tape data. In September, HSCRC staff will provide to hospitals a list of medical record numbers in CY 2012 that currently do not have an EID assigned. Hospitals will have until the end of October to submit these cases to CRISP for EID creation. Hospitals that were participating in the meeting were on board with this timeline.

7. 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.maryland.gov>).
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*.

Staff Final Recommendations Regarding Medicare's Two Midnight Rule Effective October 1, 2013

Health Services Cost Review Commission
4160 Patterson Avenue Baltimore, MD 21215
(410) 764-2605
September 4, 2013

This document contains the preliminary staff analysis and final recommendations regarding the Medicare "2 Midnight Provision," a new rule to classify Medicare patients as an inpatient or an outpatient, that is effective October 1, 2013. This recommendation was approved by the Commission.

CMS “2- Midnight Provision” HSCRC Staff Analysis and Recommendations

Statement of the Issue

The Centers for Medicare and Medicaid Services (CMS) issued a final rule on August 2, 2013 regarding the classification of hospital inpatients and outpatients. Under the new rule, which will be effective on October 1, 2013, Medicare hospital stays “crossing two midnights,” will qualify as inpatient when supported by proper physician documentation. Conversely, Medicare hospital stays spanning less than two midnights will be considered outpatient. For patients whose stay spans fewer than two midnights but the services are identified on the Medicare “inpatient-only” list of procedures, CMS will pay for an inpatient stay. CMS will also reimburse for an inpatient stay “in exceptional cases such as beneficiary death or transfer.”

The rule is an attempt by CMS to better define Medicare’s medical review criteria by drawing a definitive line between inpatient and outpatient. In doing so, CMS intends to address increasing confusion about the classification of inpatient and outpatient hospital stays. Much of the confusion has arisen over the past 10 years as technological advances have given rise to minimally invasive surgical procedures across a variety of specialties, including laparoscopic and arthroscopic techniques for gynecological and orthopedic procedures, smaller incisions for heart and vascular surgeries, and alternative surgical approaches, such as anterior hip replacement. In addition, average length of stay has declined steadily among Medicare patients, from an average of 5.41 days in 1999 to 4.67 days in 2010.¹ The decrease in average length of stay can be attributed to a variety of factors, including medical advances and care delivery improvements, as well as financial incentives for hospitals.

There has also been an increase in the number of observation cases, particularly over the last five years. An analysis of Medicare claims data by the American Hospital Directory (AHD) showed that observation cases among Medicare beneficiaries increased by 230,000 claims in 2011.² Under the new CMS 2-Midnight Provision, observation patients would be considered outpatients unless they are admitted and their care crosses two midnights after the admission order.

HSCRC Assessment of the Medicare Rule

The “2-Midnight Provision” is considered a Medicare medical policy; therefore it will apply to Maryland hospitals for their Medicare claims. The HSCRC does not establish payer medical coverage policies or benefit design. Medicaid and commercial insurers establish their own medical policies and benefit design, and, therefore, HSCRC does not intend to adopt the 2-Midnight policy for commercially insured or Medicaid patients. The provision is specifically designed by CMS to define an inpatient versus outpatient hospital stay for Medicare patients, reduce the number of

¹ *A Data Book: Health Care Spending and the Medicare Program*. Medicare Payment Advisory Commission. June 2012, p.68.

² Carlson, J., “Faulty gauge? Readmissions are down, but observational status patients are up—and that could skew Medicare numbers.” *ModernHealthcare.com*. June 8, 2013.

prolonged observation cases among these patients, and address several issues and mechanisms that are unique to the Medicare program.

According to CMS, one source of increasing Medicare costs is “improper” payment rates -- inpatient payments made for services that were determined to be more appropriately provided on an outpatient basis. For example, CMS’ Comprehensive Error Rate Testing (CERT) program found a 36 percent improper payment rate for one-day inpatient stays in 2012, i.e., 36 percent of one-day stays were paid as inpatient cases, but it was later determined that services would have been more appropriately delivered on an outpatient basis and should have been reimbursed as such.³ Maryland has also struggled with this issue as length-of-stay has decreased and one-day stay admissions increased. In 2011, HSCRC removed one-day stays from the charge per case system so that hospitals would not benefit by increasing one-day stays under the higher rates provided by the APR-DRG averages that underlie the charge per case permitted. At the same time, HSCRC established an observation rate center to allow hospitals to charge for care in the outpatient setting when one-day cases were transitioned from inpatient to outpatient. By the end of 2012, there were nearly 109,000 observation cases in Maryland and these cases have continued to increase in 2013. With increased focus on audits of one-day stays by Medicare, the average length of stay for observation cases has increased in Maryland as it has elsewhere. The table below shows distribution of observation cases in Maryland for FY 2012. It should be noted that HSCRC staff were unable to calculate the length-of-stay for observation cases based on the admission and discharge dates due to errors in the claims data. Therefore, the distribution of cases is based on the number of hours charged for each observation case.

**Observation Cases in Maryland Hospitals
FY 2012**

Length of Stay in Observation	Number of Cases	Percent of Total
< 24 hours	61,978	57%
24 to 47 hours	36,566	34%
48 hours or more	10,151	9%
TOTAL	108,695	100%

Through the 2-Midnight Provision, CMS is also attempting to address, in part, the balance between Medicare Part A and Part B spending and the cost-sharing requirements for beneficiaries under each. Cost-sharing requirements are different for beneficiaries depending on whether a hospital stay is classified as inpatient or outpatient. In addition, Medicare’s policies are designed to address the needs of its elderly patient population, which has different characteristics and needs than a commercially insured or Medicaid population. For example, Medicare publishes an annual list of inpatient-only procedures, and will reimburse hospitals for these procedures only if they are performed on an inpatient basis. Many procedures are included on this list because CMS has determined that these procedures are more appropriately performed on an inpatient basis for the elderly Medicare population. However, many hospitals, including Maryland hospitals, are

³ Memorandum Report: *Hospitals’ Use of Observation Stays and Short Inpatient Stays for Medicare Beneficiaries*, OEI-02-12-00040. Office of Inspector General, Department of Health and Human Services. July 29, 2013. p.3.

reimbursed by other payers for a substantial portion of these procedures in an outpatient setting, which medical professionals have determined to be appropriate for a younger and/or healthier population.

Finally, the mechanisms by which medical necessity and appropriateness of care are determined are different for Medicare versus commercial payers. Historically, Medicare's medical review or utilization management process has been comprised primarily of Recovery Audit Contractor (RAC) audits to determine medical necessity and appropriateness of inpatient, outpatient (including observation) classifications on a retrospective basis. Typically, commercial payers use Milliman Care Guidelines® or McKesson's InterQual® Criteria on a prospective basis for utilization management and determining the appropriateness of inpatient or outpatient care. These tools use evidence-based clinical guidelines and indicators to help hospital case managers make decisions alongside physicians caring for patients and making inpatient admission determinations. The Medicare 2-Midnight Provision attempts to create a rule-based regulation regarding medical necessity and appropriateness of care, thus prospectively and distinctly defining the parameters of inpatient and outpatient stays in the context of physicians making admission determinations while also providing guidance for medical reviewers conducting retrospective RAC audits. Many commercial payers and Medicaid are also implementing policies to limit the number and length of observation stays.

Although HSCRC does not plan to adopt the 2-Midnight Provision for uniform application across payers in Maryland, HSCRC does intend to reiterate its current policy on observation cases. Furthermore, there are implications of this Medicare provision for the charge per case and charge per episode measurements that will need to be assessed.

HSCRC Policy on Observation

In addition to research and analysis, HSCRC staff conducted calls with Medicaid and commercial payers as well as the Maryland Hospital Association in considering possible changes to our policies. Current HSCRC policy, as set forth in Commission regulation, COMAR 10.37.02, states that observation charges beyond 48 hours are not to be expected. As shown above, nearly 9 percent of observation cases in 2012 exceeded this length of stay. With Medicare's new provision and policy changes made by other payers, HSCRC would expect the number of longer observation stays to decrease significantly. As such, we expect hospitals to stop billing for observation after the 48 hours or pursue medical exceptions or inpatient admission status under payers' protocols.

Evidence suggests that CMS has designed the 2-Midnight Provision in part to reduce the number of prolonged observation stays by encouraging more timely decision making regarding whether a patient should be admitted as an inpatient or treated as an outpatient and discharged. In a similar way, HSCRC believes that observation charges past 48 hours should be substantially reduced.

Charge Per Case Implications

Although the 2-Midnight Provision is designed in part to reduce the number of observation cases among Medicare patients, CMS estimates that more of these cases will result in inpatient admissions crossing two midnights than will be classified as outpatient. CMS estimates that 400,000 Medicare cases will shift from outpatient to inpatient, while 360,000 cases will shift from inpatient to outpatient, for a net shift of 40,000 Medicare cases to inpatient status. This may include one-day inpatient stays that may shift one way or the other.

HSCRC anticipates that shifts between inpatient and outpatient classification will also occur for Medicare cases in Maryland, creating additional observation cases as well as outpatient surgery cases. While many of the cases that will shift may be included in the one-day stays that are currently excluded from the charge per case system, these cases are scheduled to be reincorporated effective January 1, 2014.

These changes, along with increased blurring of the definition of inpatient versus outpatient create challenges for a charge per case system that includes only cases that are classified as inpatient. HSCRC is less concerned with drawing a distinct line between inpatient and outpatient and more concerned that similar services are being regulated similarly, regardless of whether they are performed on an inpatient or outpatient basis. Options will be explored that may allow the establishment of a charge per case that includes inpatient as well as similar outpatient cases, with an expected implementation date of January 1, 2014. The movement of cases between inpatient and outpatient affects not only the charge per case constraints but also has important implications for evaluation of readmissions and for the development of efficiency comparisons. HSCRC staff are committed to working together with hospitals and payers in addressing technical considerations and evaluating options.

Staff Recommendation, Conclusion and Follow Up

HSCRC supports the intent of the 2-Midnight Provision to reduce prolonged observation stays and will continue to reiterate and support its policy that observation stays beyond 48 hours should be infrequent. As such, we would expect the number of longer stays to be reduced effective October 1, 2013. HSCRC will seek input from commercial payers and Medicaid to determine if the HSCRC policy is being followed after October 1. If this does not occur, we may need to initiate compliance discussions with specific hospitals or modify the existing policies

HSCRC staff will explore options to allow the establishment of a charge per case that includes inpatient as well as similar outpatient cases, with an expected implementation date of January 1, 2014.

As hospitals prepare to comply with this new Medicare rule, HSCRC staff may be called upon to address other unforeseen issues and will need to assess the impact that the changes will have on the charge per case constraint for the last quarter of 2013.

HSCRC staff will provide a follow up analysis at the November HSCRC meeting regarding the implications of this issue and follow up actions that will be required.

Amend Regulation to Move Inpatient and Outpatient Data Submissions from Quarterly to Monthly

DRAFT STAFF RECOMMENDATION

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

September 4, 2013

These draft recommendations are for Commission consideration at the September 4, 2013 Public Meeting. No action is required. Public comments should be sent to Claudine Williams at the above address or by e-mail at claudine.williams@maryland.gov. For full consideration, comments must be received by September 24, 2013.

1. Background

Currently, Maryland hospitals under the jurisdiction of the HSCRC submit patient level inpatient (including chronic and psychiatric) discharge and outpatient visit data (“Case Mix data”) to the HSCRC on a quarterly basis. Per COMAR 10.37.04.01 and 10.37.06.01, hospitals are required to submit case mix data to the Commission within 45-60 days following the last day of the quarter during which the patient was discharged or died. The case mix data feed into a number of methodologies; and this schedule has created delays in the Commission’s ability to monitor and provide feedback to hospitals in a timely manner. Clinical information derived from case mix data takes on increased significance as rate regulatory approaches evolve to encompass quality and clinical care improvement elements. Furthermore, the ability to monitor population based metrics and approved revenue under population based models is dependent on timely data to enable projections and mid-course corrections. Timely hospital-specific and state-wide data and analysis represent an essential component in the development and implementation of care intervention strategies and are highly desired by the payer and provider community as well.

2. Revising Case Mix Data Submission Due Dates for Q3 and Q4 FY 2014

For these reasons, HSCRC staff is proposing an amendment to COMAR 10.37.04.01 and 10.37.06.01 to change the quarterly inpatient and outpatient data submissions to monthly submissions, effective January 1, 2014. Staff is proposing to require all hospitals under the jurisdiction of the HSCRC to submit monthly inpatient and outpatient data to the Commission within 15 days of the last day of the month during which the patient was discharged or died. The exact due dates for data submissions will be posted on the Commission website.

Staff is proposing to delay the start date for moving the psychiatric and chronic hospitals to monthly data submissions until July 1, 2014 to accommodate the update to their data requirements effective January 1, 2014.

3. Revising Case Mix Data Submission Due Dates for Q2 FY 2014

As the proposed monthly submission is to be effective January 1, 2014, collection of FY14 Q2 data needs to be aligned with the new timelines. Staff is recommending that the Commission require hospitals to submit inpatient (including chronic and psychiatric datasets) and outpatient Q2 FY 2014 data to the Commission within 30 days after the end of the quarter during which the patient was discharged or died. This change will allow hospitals some time to get ready for monthly data submissions beginning in February 2014. The exact due dates for data submissions will be posted on the Commission website.

4. Vetting with the Hospital Industry

Staff is cognizant that this will be a significant change for the hospital industry. HSCRC staff spoke with several hospitals representing urban, rural, systems and small community hospitals in an effort to assess the feasibility of moving to monthly submission. The response was mostly favorable; however, a few hospitals indicated that they had reservations due to timing of system conversions and staff resources. Staff will work with individual hospitals to address these concerns.

5. Recommendations

Staff recommends that the Commission approve the following recommendations:

- 1) Amend COMAR 10.37.04.01 and 10.37.06.01 to require hospitals to submit patient level Inpatient and Outpatient data to the Commission within 15 days following the last day of the month during which the patient was discharged or died, effective January 1, 2014.
- 2) Delay the start date for moving the psychiatric and chronic hospitals to monthly data submissions until July 1, 2014 to accommodate the update to their data requirements effective January 1, 2014.
- 3) Require hospitals to submit inpatient, chronic, psychiatric, and outpatient Q2 FY2014 data within 30 days after the end of the quarter during which the patient was discharged or died.

Health Services Cost Review Commission

Staff Recommendation on the U.S. Department of Health
and Human Services Request for an Extension to Access
Retrospective HSCRC Confidential Patient Level Data

September 4, 2013

This final recommendation was approved by the Commission.

**Health Services Cost Review Commission
September 4, 2013**

**Recommendation on the U.S. Department of Health & Human Services' Request for an
Extension to Access Retrospective HSCRC Confidential Patient Level Data.**

1. Summary Statement

This is a request from the U.S. Department of Health & Human Services, Assistant Secretary for Preparedness and Response, Biomedical Advanced Research and Development Authority (“HHS/ASPR/BARDA”) to extend the previous approval for access to retrospective HSCRC inpatient and outpatient confidential data to include the first six months of CY 2013 (January- June). The original request for access to CY 2008 through CY 2012 was approved at the April 10, 2013 public meeting.

2. Objective

The reason for this extension request is due to a very robust outbreak of influenza A/H3N2 virus infection in the United States that included Maryland in those first six months of CY 2013. Due to this unusually harsh influenza season, HHS/ASPR/BARDA believes it is important to include data obtained during this season in their research efforts.

Investigators received approval from the Institutional Review Board (IRB) on July 30, 2013 for the above referenced extension request for the protocol entitled, “Retrospective assessment of the impact of influenza on medical utilization by Maryland residents.. As with the previous approval, these data will not be used to identify individual hospitals or patients.

3. Recommendation

For the reason stated, staff recommends that the request to extend access to the HSCRC inpatient and outpatient confidential data files for **CY 2013 (January- June)** be approved.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE



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Thomas R. Mullen

HEALTH SERVICES COST REVIEW COMMISSION

4160 Patterson Avenue, Baltimore, Maryland 21215

Phone: 410-764-2605 · Fax: 410-358-6217

Toll Free: 1-888-287-3229

hsrc.maryland.gov

Donna Kinzer
Acting Executive Director

Stephen Ports
Principal Deputy Director
Policy and Operations

Gerard J. Schmith
Deputy Director
Hospital Rate Setting

Mary Beth Pohl
Deputy Director
Research and Methodology

TO: Commissioners
FROM: Legal Department
DATE: August 28, 2013
RE: Hearing and Meeting Schedule

Public Session:

October 9, 2013 1:00 p.m., 4160 Patterson Avenue, HSCRC Conference Room

November 6, 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://hsrc.maryland.gov/commissionMeetingSchedule2013.cfm>

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