STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

John M. Colmers
Chairman

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

George H. Bone, M.D.

Stephen F. Jencks, M.D., M.P.H.

Jack C. Keane

Bernadette C. Loftus, M.D.

Thomas R. Mullen

HEALTH SERVICES COST REVIEW COMMISSION
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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

501st MEETING OF THE HEALTH SERVICES COST REVIEW COMMISSION
October 9, 2013

EXECUTIVE SESSION
12:00 p.m.

1. **Waiver Update**
2. **Personnel Matters**

* *Post-Meeting Documents* *

HEALTH SERVICES COST REVIEW COMMISSION
1:00 p.m.

1. **Review of the Minutes from the Executive Sessions and Public Meeting Minutes from September 4, 2013, and the Executive Sessions on September 23, 2013 and September 30, 2013**

2. **Executive Director's Report + Update on All-Payer Model Presentation**

3. **Docket Status – Cases Closed**

   2215R – Upper Chesapeake Medical Center
   2217A – Johns Hopkins Health System
   2218A – Johns Hopkins Health System
   2219A – MedStar Health
   2221A – Johns Hopkins Health System
   2222A – MedStar Health
   2223N – Atlantic General Hospital

4. **Docket Status – Cases Open**

   2208R – Southern Maryland Hospital Center
   2220N – University of Maryland Medical Center
   2224A – Johns Hopkins Health System
   2225A – Maryland Physicians Care
   2226A – Johns Hopkins Hospital
   2227A – MedStar Health
   2228A – University of Maryland Medical Center
   2229A – University of Maryland Medical Center

2230A – University of Maryland Medical Center
2231A – Johns Hopkins Health System
2232A – Johns Hopkins Health System
2233A – University of Maryland Medical Center

5. **Draft Recommendation on Changes for the Submission of Financial Data**

6. **Final Recommendation on Monthly Submission of Case Mix data + Comment Letters**

7. **Legal Report**
   - **10.37.04.01 Emergency**
   - **10.37.04.01 Proposed**
   - **10.37.06.01 Emergency**
   - **10.37.06.01 Proposed**

8. **Hearing and Meeting Schedule**

Phone Conference Executive Session
of the
Health Services Cost Review Commission

MINUTES

September 23, 2013

Upon motion made, Chairman John Colmers called the phone conference meeting to order at 5:00 p.m.

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

Participating in addition to Chairman Colmers, were Commissioners Bone, Keane, Mullen and Wong.

Donna Kinzer, Steve Ports and Sule Calikoglu participated representing staff.

Also participating by phone was Stan Lustman, Commission counsel.

ITEM

The Commission discussed updates to the Model Demonstration Application.

The Phone Executive Session was adjourned at 6:20 p.m.

Phone Conference Executive Session
of the
Health Services Cost Review Commission

MINUTES

September 30, 2013

Upon motion made, Chairman John Colmers called the phone conference meeting to order at 2:30 p.m.

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

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

Donna Kinzer, Steve Ports, Sule Calikoglu, and Dennis Phelps participated representing staff.

Also participating were Stan Lustman and Leslie Schulman, Commission counsel, as well as Alice Burton, Commission consultant.

ITEM ONE

The Commission discussed the proposed Final Charge to the Advisory Council as well as the makeup of the Advisory Council.

The Commission voted unanimously to approve the proposed Final Charge and the Advisory Council slate with the addition of David Salkever, Ph.D.

ITEM TWO

The Commission discussed potential changes to its statutory and regulatory authority.

The Executive Session was adjourned at 3:27 p.m.

MINUTES OF THE
500th MEETING OF THE
HEALTH SERVICES COST REVIEW COMMISSION

September 4, 2013

Chairman John Colmers called the meeting to order at 1:04 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 present.

REPORT OF THE SEPTEMBER 4, 2013 EXECUTIVE SESSION

Dennis Phelps, Associate Director-Audit & Compliance, summarized the minutes of the September 4, 2013 Executive Session.

ITEM I
REVIEW OF THE MINUTES OF THE JULY 10, 2013 EXECUTIVE SESSION AND PUBLIC MEETING

The Commission voted unanimously to approve the minutes of the July 10, 2013 Executive Session and Public Meeting.

ITEM II
EXECUTIVE DIRECTOR'S REPORT

Ms. Donna Kinzer, Acting Executive Director, reported that Monitoring Maryland Performance (MMP) indicated that the rate of growth in charge per case increased 2.04% for the fiscal year June 30, 2013 and that inpatient revenue decreased by 1.61%. Ms. Kinzer stated that for the same period the number of inpatient cases decreased 3.58%. FY 2013 outpatient revenue increased 9.13% with total gross revenue increasing by 2.39%.

According to Ms. Kinzer preliminary FY 2013 unaudited operating profits for acute hospitals is .72%, total profit margin for the year is 3.39% and the median hospital profit is 1.10%, with a distribution of (1.32%) in the 25th percentile and 4.76% in the 75th percentile. Ms. Kinzer reminded Commissioners that Meaningful Use Funds are included in these numbers as operating revenue and may overstate the operating revenue amounts.

Ms. Kinzer noted that 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. Staff will present a recommendation later in this meeting regarding monthly case mix data. Ms. Kinzer also stated that at the October Public Meeting staff will present a recommendation for revising monthly financial and statistical

reporting changes.

Ms. Kinzer stated that CMS has instituted new billing requirement for Medicare in Maryland hospitals effective October 1st. 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. Prior to October 1st Maryland hospitals have been exempt from reporting the POA indicator. This coding is very important because the POA will form the basis for both quality and cost comparisons for Medicare in 2014 and beyond. HSCRC staff urges hospitals to pay close attention to depth of coding and POA indicators for Medicare beginning October 1st. HSCRC staff will work with the Maryland Hospital Association to provide training and guidance.

Ms. Kinzer noted effective October 1st, 2013 Medicare will implementing a "2 midnight rule" that will result in most 0 to 1 day stays being classified as outpatient for Medicare. To deal with this new rule, Staff will present a final recommendation later in this meeting regarding "Medicare's Two Midnight Rule".

Ms. Kinzer stated that discussions continue with the federal government concerning the State's Model Demonstration Proposal. In the next month HSCRC staff expects to release plans for work, make call for white papers of selected technical issues, and gain input on a public process in its evaluation of approaches and requirements for new care and payments models..

ITEM III
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

ITEM IV
DOCKET STATUS CASES OPEN

Upper Chesapeake Medical Center – 2215R

On June 14, 2013, Upper Chesapeake Medical Center submitted an application requesting a rate for Radiation Therapy (RAT) services. The Hospital currently has a rebundled rate for RAT services. The hospital is requesting that the new RAT rate be effective September 1, 2013. After reviewing the application, staff recommended:

1. That the 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; and
3. That the RAT rate not be rate realigned until a full year's cost experience data have been

reported to the commission.

The Commission voted unanimously to approve staff's recommendation.

Johns Hopkins Health System – 2217A

On July 24, 2013, the Johns Hopkins Health System (the System) filed an application on behalf of its member hospitals. The System requests approval from the HSCRC to add pediatric and adult live donor liver transplant to the global rate arrangement for solid organ and bone marrow transplant services with CIGNA Health Corporation that was approved at the Commission's December 5 2012 public meeting . The System requested that the Commission approve the revised arrangement effective September 1, 2013 with an expiration date of December 31, 2013.

The staff recommended that the Commission approve the Hospitals' request to add pediatric and adult live donor liver transplant to the existing solid organ and bone marrow alternative rate arrangement with CIGNA Health Corporation effective September 1, 2013 with an expiration date of December 31, 2013, that Hospital file a renewal application 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.

John Hopkins Health System– 2218A

On July 24, 2013, the Johns Hopkins Health System ("System") filed a renewal application on behalf of the John Hopkins Bayview Medical Center (the Hospital) requesting approval for continued participation in a capitation arrangement among the System, 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". Under this program, HEP provides services for a Medicare and Medicaid dually eligible population of frail elderly. The System is requesting approval for a period of one year effective September 1, 2013.

The staff recommended that the Commission approve the Hospital's renewal application for an alternative method of rate determination for a one year period beginning on September 1, 2013 and that the approval is 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 vote.

MedStar Health – 2219A

MedStar Health filed an application with the HSCRC on July 26, 2013 on behalf of Union Memorial Hospital and Good Samaritan Hospital (the "Hospitals") requesting approval to continue its participation in a global rate arrangement with Kaiser Foundation Health Plan of the Mid-Atlantic for cardiovascular services for a period of one year beginning October 1, 2013.

The staff recommended that the Commission approve the Hospitals' application for an alternative method of rate determination for cardiovascular services, for a one year period commencing October 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. Commissioner Loftus recused herself from the discussion and vote.

Johns Hopkins Health System – 2221A

Johns Hopkins Health System ("System") filed an application with the HSCRC on August 1, 2013 on behalf of Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center and Howard County General Hospital (the Hospitals) requesting approval to continue its participation in a global rate arrangement with the Canadian Medical Network for cardiovascular procedures, kidney transplant services and bone marrow transplant for a period of one year beginning September 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 September 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.

MedStar Health – 2222A

MedStar Health filed an application with the HSCRC on August 1, 2013 on behalf of Union Memorial Hospital and Good Samaritan Hospital (the "Hospitals") requesting approval to continue its participation in a global rate arrangement with MAMSI for orthopedic services for a period of one year beginning September 1, 2013.

The staff recommended that the Commission approve the Hospitals' application for an alternative method of rate determination for orthopedic services, for a one year period commencing September 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.

Atlantic General Hospital – 2223N

On August 2, 2013, Atlantic General Hospital submitted an application requesting a rate for Lithotripsy (LIT) services. The hospital is requesting that the new LIT rate be effective August 1, 2013.

After reviewing the application, staff recommended:

1. That the 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.

The Commission voted unanimously to approve staff's recommendation.

Medicaid Health Choice Program

Mr. Steve Ports summarized staff's draft recommendations for the applications of MedStar Health System on behalf of MedStar Family Choice; Maryland General Hospital, St. Agnes Health system, Western Maryland Health System and Meritus Health on behalf of Maryland Physicians Care and Johns Hopkins Health System on behalf of Priority Partners, Inc. for continued participation in the Medicaid Health Choice Program for one year beginning January 1, 2014.

Mr. Ports announced that the final recommendations will be presented at the October 9, 2013 public meeting.

ITEM V
FINAL RECOMMENDATION FOR THE EXPANSION of REQUIRED HEALTH INFORMATION EXCHANGE DATA TO SUPPORT POPULATION – BASED METHODOLOGIES

Ms. Claudine Williams presented a final 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 noted the following changes from the "draft" recommendation:

1. Phone number was added as a required data field for submission to CRISP. CRISP uses the phone number to help create the Master Patient Index ('MPI").
2. CRISP has developed a required data field list for historical data that hospitals are being requested to submit for calendar year 2012.

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 based on CRISP's historical data field list requirement.

Tracy LaValle, Assistant Vice President-Financial Policy and Operations of the Maryland Hospital Association, voiced support of the Staff's recommendation.

The Commission voted unanimously to approve staff's recommendation.

ITEM VI
FINAL RECOMMENDATION REGARDING MEDICARE'S TWO MIDNIGHT RULE EFFECTIVE OCTOBER 1, 2013

Ms. Donna Kinzer presented the final recommendation Regarding Medicare Two Midnight Rule. (see, "Staff's Final Recommendation Regarding Medicare's Two Midnight Rule Effective October 1, 2013" on the HSCRC website).

CMS issued a final rule on August 2, 2013 regarding the classification of hospital inpatients and outpatients. Under this rule effective October 1, 2013, Medicare hospital stays crossing 2 midnights will qualify as inpatient when supported by proper physician documentation. Medicare stays spanning less than 2 midnights will be considered outpatient. For patients whose stay spans fewer than 2 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.

HSCRC staff stance is that the "2 Midnight Provision" is considered a Medicare medical policy therefore it will apply to Maryland hospitals for Medicare claims. The HSCRC does not establish payor medical coverage policies or benefit design. Medicaid and commercial insurers establish their own medical policies and benefit design. Therefore the HSCRC does not intend to adopt the 2-Midnight policy for commercially insured or Medicaid patients.

Staff expects that observation stays beyond 48 hours will be reduced by October 1st, 2013. If such observation cases do not decrease, the HSCRC may be forced to modify existing policies.

Staff will explore policy changes that would establish a charge per case methodology that includes inpatient as well as similar outpatient observation cases. The goal to implement this revised methodology by January 1, 2014. Ms. Kinzer noted that if staff cannot develop a policy

that includes both one day stays and observation within the CPC system, they would continue to exclude one day stays from inpatient constraint. Staff will update the commissioners at the November meeting with a report of the implementation of the new rule and any other follow up activities.

Commissioners Bone and Jencks express their concern about how the "Two Midnight Rule" will impact physician decision making and how this rule will be explained to patients.

Ms. Traci LaValle Assistant Vice President-Financial Policy and Operations of the Maryland Hospital Association, voiced support of the Staff's recommendation and stated that MHA is planning an educational session to help hospitals understand the new rule

The Commission voted unanimously to approve staff's recommendation.

ITEM VII
DRAFT RECOMMENDATION on MONTHLY SUBMISSION of CASE MIX DATA

Ms. Claudine Williams presented a draft recommendation to amend the Monthly Submission of Case Mix Data. (see, "Monthly Submission of Case Mix Data" on the HSCRC website).

Ms. Williams noted that currently Maryland hospitals per COMAR 10.37.04.01 and 10.37.06.01 are required to submit case mix data to the commission within 45-60 days following the end of the quarter during which the patient was discharged or died. This submission requirement is creating delays in the Commission's ability to monitor and provide feedback to hospitals in a timely manner. 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.

To correct this problem, 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 submission to monthly submissions, effective January 1, 2014. Staff is also proposing to require all hospitals under the jurisdiction of the HSCRC to submit monthly inpatient and outpatient data within 15 days of the last day of the month during which the patient was discharge or died.

In addition, Staff is proposing that the monthly data submission requirement for psychiatric and chronic hospitals become effective July 1, 2014 to accommodate the update to their data requirements effective January 1, 2014.

Finally staff is recommending that the Commission require all hospitals (including chronic and psychiatric hospitals) to submit inpatient and outpatient for FY 2014 quarter 2 data within 30 days after the quarter the patient was discharged or died. This change will allow hospitals time to get ready for the monthly data submissions beginning in February, 2014.

Since this is a draft recommendation, no action was required by the commissioners.

ITEM VII
CONFIDENTIAL DATA EXTENSION REQUEST

Ms. Claudine Williams presented a recommendation to extend the U.S Department of Health & Human Services' Request for an Extension to Access Retrospective HSCRC Confidential Patient Level Data.

Per Ms. Williams this request came from the U.S Department of Health and Human Services, Assistant Secretary for Preparedness and Response, Biomedical Advance Research and Development 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 FY 2012 was approved at the April 10 public meeting.

The reason for this extension request is due to a robust outbreak of influenza in the US that included Maryland for the 1st 6 months of CY 2013.

Staff recommends that the request to extend access to the HSCRC inpatient and outpatient confidential data files for CY 2013 (January-June) be approved.

The Commission voted unanimously to approve staff's recommendation.

HEARING AND MEETING SCHEDULE

October 9, 2013	Time to be determined, 4160 Patterson Avenue, HSCRC Conference Room
November 6, 2013	Time to be determined, 4160 Patterson Avenue, HSCRC Conference Room

There being no further business, the meeting was adjourned at 2:11 p.m.

EXECUTIVE DIRECTOR'S REPORT
OCTOBER 9, 2013

Monitoring Maryland Performance

Charges per Case

For Twelve Months Ended August 2013

- Charge per Case increased 2.33%
  - For YTD ended August 2013 versus the same time period in 2012, CPC increased 3.21%
- Cases (admissions + new born) decreased (3.82%)
- Inpatient revenue decreased (1.57%)
- Outpatient revenue increased 6.67%
- Total gross revenue increased 1.55%
  - For YTD ended August 2013 versus the same period in 2012, total gross revenue increased 0.67%.

Next month, this report will incorporate charge per capita concepts and will include highlights on a hospital specific basis where warranted.

Financial Condition

Data are available for profits for the first two months of FY 14 (July through August 2013). For this year to date period, average operating profits for all acute care hospitals was 1.36%. The total profit margin for this period is 3.59 percent. The median hospital had an operating profit of 1.57%, with a distribution as follows:

- 25th percentile at -1.92%
- 75th percentile at 3.89%

Progress on Demonstration Request

The Governor submitted the State's Model Demonstration Proposal to the Federal government on March 26, 2013. Un updated proposal draft has been posted to the Department of Mental Health and Hygiene Website. Comments have been received and a revised application will be filed shortly. http://dhmh.maryland.gov/newsroom1/Pages/DHMH-Posts-Revised-Proposal-for-Modernization-of-MD%27s-All-Payer-Hospital-System-for-Comment.aspx.

Implementation activities have already begun for a proposed start date of January 1, 2014. The powerpoint reviewing implementation activities will be posted on the HSCRC website and a section of the website will provide implementation updates starting later this week.

New Reporting Requirements Summary

- Final policy on reporting to CRISP for all outpatient activities (September)
- Final policy on case mix reporting (this month)
- Draft policy on monthly financial and utilization reporting (this month)

Upcoming Activities

Interim implementation policies: Interim policies relative to implementation of proposed All-Payer model will be introduced at the November HSCRC meeting, with an expected effective date of January 1. These will include interim changes to variable cost policies, payment model approaches, a January 1 rate order update, and discussion of open rate period settlements.

Charge per case update: On January 1, unless HSCRC is able to incorporate outpatient cases into the Charge Per Case (CPC) approach, we will continue to maintain the same case mix method currently in place, with the usual update process (including transition to the APR-DRG grouper 30). We will hold off on reincorporating 0-1 day stays until we can also incorporate related outpatient cases. Staff will also plan to decrease the Admissions Readmissions Revenue for any growth in rehospitalizations occurring in observation status beyond the one day timeframe. HSCRC staff preference is to incorporate both inpatient and outpatient activity into the new CPC update. However, the timeframe to do this by January 1 is short. We will continue to work with the industry to determine the feasibility and will report progress at the December meeting along with any policy updates needed.

Two-midnight rule: Medicare implemented a change in billing and medical policy relative to the definition of inpatient versus outpatient status for certain short stay patients. HSCRC reiterated its policy regarding expected limits to outpatient observation billing beyond 48 hours effective October 1, 2013. We are soliciting further input from payers and providers regarding the impact of this change and will report results at the November HSCRC meeting.

Uncompensated care update: HSCRC has been reviewing the FY 2014 updates to the funding requirements (net payments or net receipts by hospital) applicable to the uncompensated care pool. Overall, the uncompensated care levels used for FY 2014 and FY 2013 are about the same overall. However, there are variations across hospitals, particularly in reporting of charity care. HSCRC staff is concerned about the allocation between bad debts and charity care reported by some hospitals. HSCRC staff will propose to suspend the "multiplier" for charity care in applying the uncompensated care policy at the November meeting unless we are able to resolve this concern. Staff also notes that a new approach will be required for uncompensated care next July due to the additional enrollment in Medicaid and exchanges under the Affordable Care Act. HSCRC staff will be inviting a white paper on this topic as well as analyzing case-mix data and CRISP data to better understand changes that occur.

Rate Orders and Upcoming Rate Activities: January 1 rate orders will contain settlements for the year ended June 30, 2013 as well as adjustments for other items deferred and one-time adjustments. Settlements for volume, price, and case mix activity from July 1, 2013 through December 31, 2013 will occur with the July 2014 update.

CON Applications

HSCRC staff has been informed regarding the expected filing of several significant CON applications. We will need to modify our financial feasibility review of these applications in light of the changes that will be expected to occur under the proposed All-Payer model.

Disclosure Report

According to the Commission's annual disclosure report, patients at Maryland's hospitals paid, on average, $11,984 for a hospital admission in FY 2012, up from the $11,711 paid in the previous fiscal year. This resulted in a 2.3 percent level of growth and is below the estimated national average increase of 3.4 percent for the same period. The mark-up in Maryland's costs (i.e., the difference between hospital costs and what hospitals ultimately charge patients) continues to be the lowest in the nation. The mark-up in Maryland hospitals averaged 33 percent, while the average mark-up for hospitals nationally is 220 percent, according to the most recent data from the American Hospital Association.

Further, an analysis of hospital costs (i.e., what hospitals expend to provide their services) shows that the average cost per admission at Maryland hospitals increased by 3.8 percent compared with an estimated 3.5 percent increase for the rest of the nation for FY 2012. Had cost per admission in Maryland risen at the national rate during the period 1976 through 2011, aggregate hospital expenditures would have been $52 billion more.

The report also showed that:

1. Uncompensated care (i.e., bad debt and charity care) was $ 1 billion in FY 2012 (6.9 percent of gross patient revenue) compared to $971 million in FY 2011.
2. Hospital operating profits decreased in FY 2012:
    - Total profits (otherwise known as "excess profit"), which include profits and losses from operating and non-operating activities (both regulated and unregulated), decreased from $ 847 million in FY 2011 (6.2 percent of total revenue) to $230 million (1.7 percent of total revenue) in FY 2012.
    - Operating profits on regulated activities alone in FY 2012 decreased to $781 million (6.3 percent of regulated net operating revenue) from the previous year's $897 million (7.4 percent of regulated net operating revenue).
    - Operating profits from both regulated and unregulated activities decreased from $464 million in FY 2011 (3.5 percent of total net operating revenue) to $315 million (2.3 percent of total net operating revenue in FY 2012), attributable in part to increased losses sustained by hospitals for physician-related activity.
3. Total net regulated patient revenue increased by only 3 percent to $12.3 billion in FY 2012 from $11.9 billion in FY 2011, due, in part, to a 3.8 percent decrease in admissions.

Update on New All-Payer Model for Maryland and Appointment of Advisory Council

October 9, 2013

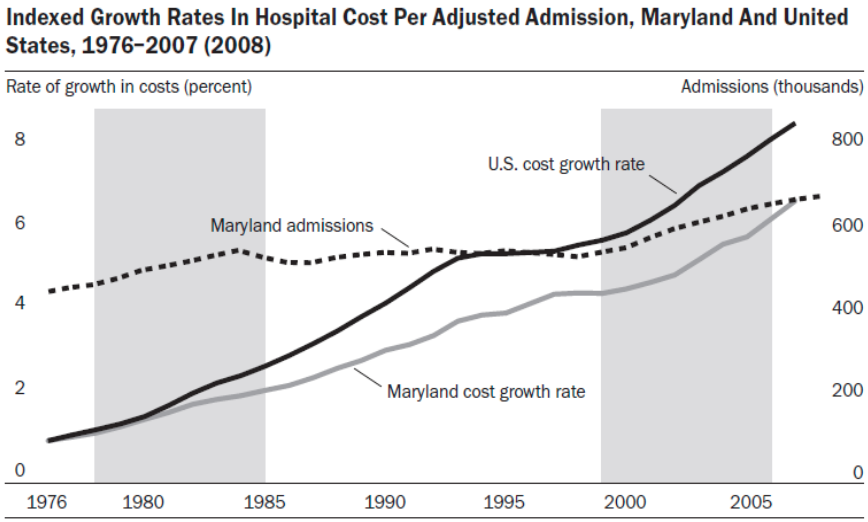
Maryland Health Services Cost Review Commission

Overview

- Request submitted to CMS and CMMI in March, update in October
- Would move Maryland to an **all payer**, **total hospital** payment **per capita** test.
  - Also requires additional Medicare savings, and specific reductions in readmissions & hospital acquired conditions
  - Shifts focus to population health and delivery system redesign
- Will require federal approval process before implementation
- Implementation activities underway for requested January 1 start date

Maryland HSCRC Accomplishments

- Cost containment (all payer)
  - From 26% above the national average cost per case in1976
  - To 2% below the national average in 2007



- Equitable funding of uncompensated care, payer equity, and equal access
- Stable and predictable payment system for hospitals
- Robust data and comprehensive analytic and rate setting tools
- Transparency through uniform accounting and reporting
- Leader in linking quality and payment (MHAC, QBR)
- Modern health information exchange with real time data on admissions and ER visits and hot spotting capabilities

HSCRC
Health Services Cost Review Commission

Proposed Maryland All-Payer Model

- **A new All-Payer model** focused on improving health care quality, delivery of services, and the affordability of health care.
- **A new approach to Maryland's all-payer hospital waiver—**from Medicare payment per admission, to a new model that focuses on overall hospital expenditures, while also requiring improvements in quality / efficiency
- **Strong incentives for better outcomes at lower cost**, moving to global and episode reimbursement models with strong incentives for improved quality and reductions of preventable utilizations and conditions

Alignment with Other Efforts

- New model designed to work together with a number of other efforts currently underway
  - Strengthen primary care and patient-centered care coordination
  - Map and track preventable disease and health costs
  - Develop public-private coalitions for improved health outcomes
  - Establish health enterprise zones
  - Enroll Marylanders in health coverage through Maryland Health Connection

Proposed Model Creates New Context for HSCRC

- Align payment with new ways of organizing and providing care
- Contain growth in total cost of hospital care in line with requirements
- Evolve value payments around efficiency, health and outcomes

Better care

Better health

Lower cost

Near Term Implementation Efforts

- Prior to January 1
  - Reporting and monitoring changes
  - Transitional policies effective January 1
  - Meetings of HSCRC and Advisory Council
  - Call for white papers and continued planning cycle for Work Groups
  - Work plan on shared savings models with physicians underway
  - Focused analysis on avoidable utilization and quality opportunities
  - January 1 settlement of deferred July adjustments
- After January1, begin longer term design efforts with well developed work group structure

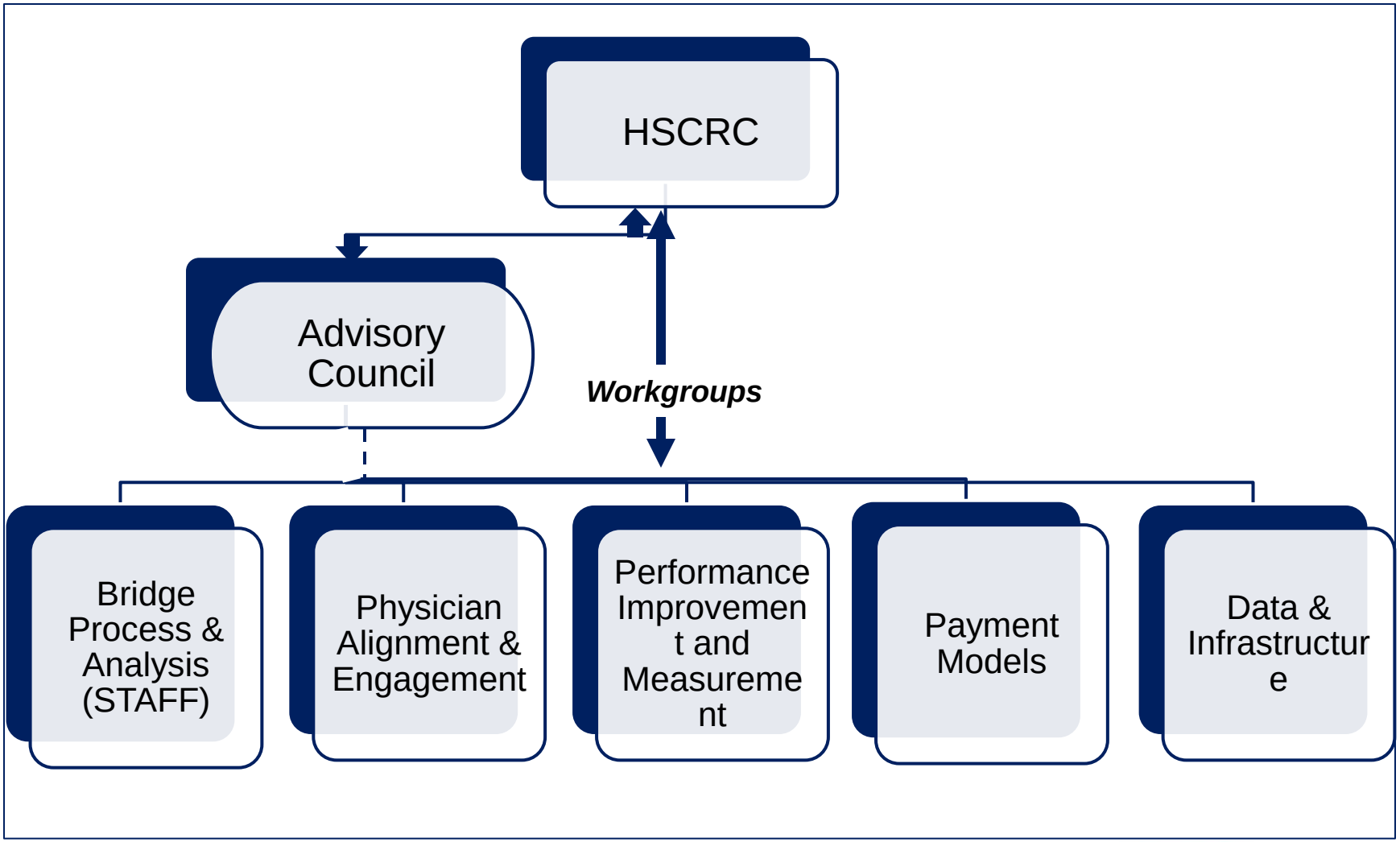
Public Engagement Approach-Framework

- **Need.** The Health Services Cost Review Commission (HSCRC) is preparing for the implementation of a new All-Payer Model based on its revised application to the Centers for Medicare & Medicaid Innovation.
- **Overview of Proposed Framework.** An Advisory Council will provide broad input on the guiding principles for the HSCRC to consider in implementation of the new Payment Systems design. Work Groups will be convened on specific topics and will provide advice on longer term policy changes. The Council and Work Groups are non-voting and will conduct their work in public. Reports will be prepared detailing areas of consensus and divergence.
- **Transparency (Public Meetings and Materials):** The Advisory Council and Work Groups will convene public meetings. Meeting dates and materials will be posted on-line on the HSCRC website.

Public Engagement Approach-Overview

- **Advisory Council:** The purpose of the Advisory Council is to provide the HSCRC with senior-level input on guiding principles for overall implementation.
- **Work Groups:** The purpose of the Work Groups is to provide expertise, particularly on the state of the art and the feasibility of possible solutions. HSCRC will solicit expert data analyses and papers on several methodological issues and policy questions that will be provided to the Work Groups to support an informed process.
- **Bridge Process.** While the Advisory Council and Work Groups will be considering long-term changes to the payment system to meet the goals of the new All-Payer Model, a Bridge Process will be used to implement the short term changes and interim solutions. The Bridge Process will be managed by the HSCRC staff. Input will be sought from stakeholders and public processes will be followed.

Implementation Planning Structure



Appointment of Advisory Council

David Blumenthal, MD (invited)
President
The Commonwealth Fund

Chet Burrell
President and CEO
Care First

Robert A. Chrencik
President and Chief Executive Officer
University of Maryland Medical System

Carmela Coyle
President and CEO
Maryland Hospital Association

Willarda Edwards, MD
Managing Partner
Internal Medicine Practice

Dean Farley
Senior Vice President
OptumInsight

Rachel Monroe (invited)
President
Weinberg Foundation

Chuck Milligan
Deputy Secretary for Health Financing, DHMH (Medicaid)

Peggy Naleppa
President and CEO
Peninsula Regional Medical Center

Gene Ransom
CEO
MedChi
(The Maryland State Medical Society)

Joe Ross
President and CEO
Meritus Medical Center

David Salkever
Health Economist
JHU Bloomberg School of Public Health and UMBC

Kevin Sexton
President and CEO
Holy Cross

Gary Simmons
Senior Vice President
Networks, Mid Atlantic Health Plans, United HealthCare

Eric Wagner
Executive Vice President
External Affairs and Diversified Operations
MedStar Health

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Health Services Cost Review Commission

HSCRC Website

- More details will be posted regularly on the website
- Specific examples:
  - Call for white papers and data analysis
  - Work Group charters and meeting materials
  - Implementation policies

Success Factors

- The new models have enormous potential to improve the efficiency and effectiveness of care and the health of Marylanders,
- The HSCRC and the stakeholders face an unprecedented need to work together, focusing on improved quality and reduced cost, to make design of the new system and implementation of the transition successful.
- Maryland needs to demonstrate that Better Health, Improved Care, and Lower Costs will result when changes in financing and delivery are implemented in the context of an All-Payer System
- Thank you for your input and assistance with this important process

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

AS OF OCTOBER 1, 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	11/6/2013	PEDS	CK	OPEN
2220N	University of Maryland Medical Center	8/1/2013	9/4/2013	12/30/2013	TRAUMA	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
2228A	University of Maryland Medical Center	5/13/2013	N/A	N/A	ARM	DNP	OPEN
2229A	University of Maryland Medical Center	9/10/2013	N/A	N/A	ARM	DNP	OPEN
2230A	University of Maryland Medical Center	9/10/2013	N/A	N/A	ARM	DNP	OPEN
2231A	Johns Hopkins Health System	9/23/2013	N/A	N/A	ARM	DNP	OPEN
2232A	Johns Hopkins Health System	9/27/2013	N/A	N/A	ARM	DNP	OPEN
2233A	University of Maryland Medical Center	9/30/2013	N/A	N/A	ARM	DNP	OPEN

NONE

PROCEEDINGS REQUIRING COMMISSION ACTION - NOT ON OPEN DOCKET

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**

Final Recommendation

October 2, 2013

This is a final recommendation and ready for Commission action

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 certai n non-hospital services, in return for a State-determined capitation paym ent. Priority Part ners pays the Hospitals HSCRC-approved rates f or hospital services used by its enrollees. The Ho spitals supplied information on th eir most recen t experience and their p reliminary projected revenues and expenditures for the upcom ing year based on the initial revised Medicaid capitation rates.

Priority Partners is a m ajor 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 initi al approval in proceeding 2178A. Staff reviewed the operating perform ance under the contract as well as the terms of the capitation pricing agreement. Staff has analyzed Priority P artner's financial history, net income projections for CY 2013, and pr ojections for CY 2014. The statem ents provided by Priority Partners to staff represent both a "standalone" and "consolidated " view of Priority's operations . The consolidated picture reflects certain adm inistrative revenues and expenses of Johns Hopkins Health Care. W hen other provider-based MCOs are evaluated f or financial stability, their administrative costs relative to their MCO busine ss are in cluded as well; however, they are all included under one entity.

In recent years, the consolidated financial perfor mance of Priority Partners has b een favorable. The actual financial exp erience reported to staff for CY2 012 was positiv e, 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 perform ance, staff believes that the proposed renewal arrangem ent for Priority Partners is acceptable under Commission.

Therefore:

1) **Staff recommends approval of this alternativ e rate application for a one-year period beginning January 1, 2014.**
2) **Since sustained losses over an extended peri od 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 MC Os expected financial status in to 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 C Y 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 evaluatio n of applications for alternative methods of ra te determination, the staff recommends that this a pproval be contingent upon th e continued adherence to the standard Memorandum of Understanding w ith the Hospitals for the approved contract. This document formalizes the understanding be tween the Commission and the Hospitals, and includes provisions for such things as payments of HSCRC-approved rates, treatment of losses tha t may be attribut ed to the managed care contract, quarterly and annual reporting, the confidentialit y 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**

Final Recommendation

October 2, 2013

This is a final recommendation and ready for Commission Action

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 APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION	*	**COMMISSION**	
JOHNS HOPKINS HEALTH	*	**DOCKET:**	**2013**
SYSTEM	*	**FOLIO:**	**2036**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2226A**

Staff Recommendation

October 9, 2013

I. INTRODUCTION

Johns Hopkins Health System ("System") filed a renewal application with the HSCRC on August 27, 2013 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 for continued participation in a global rate arrangement for solid organ and bone marrow transplants with Preferred Health Care LLC. The Hospitals request that the Commission approve the arrangement for one year beginning October 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 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 that it has been active in similar types of fixed fee contracts for several years, and that

JHHC is adequately capitalized to bear the risk of potential losses.

V. STAFF EVALUATION

Although there was no activity under this arrangement in the last year, staff is satisfied that the hospital component of the global prices, which has been updated with current data, is sufficient for the Hospitals to achieve favorable experience under this arrangement.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for solid organ and bone marrow transplant services, for a one year period commencing 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 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 ALTERNATIVE	*	**BEFORE THE HEALTH**	
RATE APPLICATION OF	*	**SERVICES COST REVIEW**	
MEDSTAR HEALTH	*	**COMMISSION**	
SYSTEM	*	**DOCKET:**	**2013**
	*	**FOLIO:**	**2037**
COLUMBIA, MARYLAND	*	**PROCEEDING:**	**2227A**

Final Recommendation

October 2, 2013

This is a final recommendation and ready for Commission action

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.

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION	*	**COMMISSION**	
UNIVERSITY OF MARYLAND	*	**DOCKET:**	**2013**
MEDICAL CENTER *		**FOLIO:**	**2038**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2228A**

Staff Recommendation

October 9, 2013

INTRODUCTION

The University of Maryland Medical Center ("Hospital") filed a renewal application with the HSCRC on May 23, 2013 requesting approval to continue to participate in a global rate arrangement for blood and bone marrow transplants for three years with the BlueCross and BlueShield Association Quality Centers for Transplant (BQCT) beginning September 1, 2013.

II. OVERVIEW OF APPLICATION

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

III. FEE DEVELOPMENT

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

IV. IDENTIFICATION AND ASSESSMENT OF RISK

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

V. STAFF EVALUATION

The staff found that the actual experience under this arrangement for the prior year has been favorable.

STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospital's application for an alternative method of rate determination for blood and bone marrow transplant 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 Hospital for the approved contract. This document will formalize the understanding between the Commission and the Hospital, 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 cann-ot be used to justify future requests for rate increases.

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION	*	**COMMISSION**	
UNIVERSITY OF MARYLAND	*	**DOCKET:**	**2013**
MEDICAL CENTER	*	**FOLIO:**	**2039**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2229A**

Staff Recommendation

October 9, 2013

I. INTRODUCTION

The University of Maryland Medical Center (the Hospital) filed a renewal application with the HSCRC on September 10, 2013 for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The Hospital requests approval from the HSCRC to continue to participate in a global rate arrangement for solid organ and blood and bone marrow transplant services with OptumHealth Care Solutions, Inc. for a one-year period, effective November 1, 2013.

II. OVERVIEW OF APPLICATION

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

III. FEE DEVELOPMENT

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

V. STAFF EVALUATION

The staff found that the actual experience under this arrangement for the prior year has

been favorable.

VI. STAFF RECOMMENDATION

Staff recommends that the Commission the Commission approve the Hospital's application to continue to participate in an alternative method of rate determination for solid organ and blood and bone marrow transplant services for a one year period beginning November 1, 2013.

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

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION	*	**COMMISSION**	
UNIVERSITY OF MARYLAND	*	**DOCKET:**	**2013**
MMEDICAL CENTER	*	**FOLIO:**	**2040**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2230A**

Staff Recommendation

October 9, 2013

I. INTRODUCTION

University of Maryland Medical Center (the Hospital) filed an application with the HSCRC on September 10, 2013 seeking approval to participate in an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The Hospital requests approval from the HSCRC to continue to participate in a global rate arrangement for solid organ and blood and bone marrow services with Interlink Health Services for a period of one year beginning November 1, 2013.

II. OVERVIEW OF APPLICATION

The contract will continue to be held and administered by University Physicians. Inc. ("UPI"), which is a subsidiary of the University of Maryland Medical System. UPI will manage all financial transactions related to the global price contract including payments to the Hospital and bear all risk relating to 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 solid organ and blood and bone marrow transplant services at the Hospital. 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 UPI for all contracted and covered services. UPI is responsible for billing the payer, collecting payments, disbursing payments to the Hospital at its full HSCRC approved rates, and reimbursing the physicians. The Hospital contends that the arrangement among UPI, the Hospital, and the physicians holds the Hospital harmless from any shortfalls in payment from the global price contract. UPI maintains that it has been active in similar types of fixed fee contracts for several years, and that UPI is adequately capitalized to bear the risk of potential losses.

V. STAFF EVALUATION

Staff found that there was no experience under this contract for the previous year. Although

there was no experience last year, staff believes that the Hospital can achieve a favorable experience under this arrangement.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospital's application for an alternative method of rate determination for solid organ and blood and bone marrow transplant services for a one year period commencing November 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 would formalize the understanding between the Commission and the Hospital, and would include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION	*	**COMMISSION**	
JOHNS HOPKINS HEALTH	*	**DOCKET:**	**2013**
SYSTEM	*	**FOLIO:**	**1996**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2231A**

Staff Recommendation

October 9, 2013

INTRODUCTION

Johns Hopkins Health System (System) filed a renewal application with the HSCRC on September 23, 2013 on behalf of the Johns Hopkins Bayview Medical Center (the "Hospital") for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System requests approval from the HSCRC for continued participation in a capitation arrangement serving persons with mental health needs under the program title, Creative Alternatives. The arrangement is between the Johns Hopkins Health System and the Baltimore Mental Health Systems, Inc., with the services coordinated through the Hospital. The requested approval is for a period of one year beginning November 1, 2013.

II. OVERVIEW OF APPLICATION

The parties to the contract include the System and the Baltimore Mental Health Systems, Inc. Creative Alternatives provides a range of support services for persons diagnosed with mental illness and covers medical services delivered through the Hospital. The System will assume the risks under the agreement, and all Maryland hospital services will be paid based on HSCRC rates.

III. STAFF FINDINGS

Staff found that the experience under this arrangement for FY 2013 was essentially break-even.

IV. STAFF RECOMMENDATION

Although the arrangement only broke even in FY2013, based on historical experience, staff believes that the Hospital can again achieve a favorable result under this arrangement. Therefore, staff recommends that the Commission approve the Hospital's renewal application for an alternative method of rate determination for a one year period commencing November 1, 2013.

Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospital for the approved contract. This document would formalize the understanding between the Commission and the Hospital, and would include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, confidentiality of data

submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION	*	**COMMISSION**	
JOHNS HOPKINS HEALTH	*	**DOCKET:**	**2013**
SYSTEM	*	**FOLIO:**	**2043**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2232A**

Staff Recommendation

October 9, 2013

I. INTRODUCTION

Johns Hopkins Health System (System) filed an application with the HSCRC on September 27, 2013 on behalf of Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center (the Hospitals) for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System requests approval from the HSCRC for participation in an amended global rate arrangement for solid organ transplant, bone marrow transplant, and cardiovascular services with Olympus Managed Health for a period of one year beginning November 1, 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 manage all financial transactions related to the global price contract including payments to the Hospitals and bear all risk relating to regulated services associated with the contract.

III. FEE DEVELOPMENT

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

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

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for solid organ, bone marrow transplant, and cardiovascular services for a one year period commencing November 1, 2013. The Hospitals will need to file a renewal application for review to be considered for continued participation. Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospitals for the approved contract. This document would formalize the understanding between the Commission and the Hospitals, and would include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION	*	**COMMISSION**	
UNIVERSITY OF MARYLAND	*	**DOCKET:**	**2013**
MEDICAL CENTER	*	**FOLIO:**	**2043**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2233A**

Staff Recommendation

October 9, 2013

I. INTRODUCTION

The University of Maryland Medical Center (the Hospital) filed a renewal application with the HSCRC on September 30, 2013 for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The Hospital requests approval from the HSCRC for participation in a new global rate arrangement for solid organ and blood and bone marrow transplant services with Humana for a one-year period, effective December 1, 2013.

II. OVERVIEW OF APPLICATION

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

III. FEE DEVELOPMENT

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

V. STAFF EVALUATION

After review of the data utilized to calculate the case rates, staff believes that the

Hospitals can achieve a favorable experience under this arrangement.

VI. STAFF RECOMMENDATION

Staff recommends that the Commission approve the Hospital's application for an alternative method of rate determination for solid organ and blood and bone marrow transplant services for a one year period beginning December 1, 2013.

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

Amend Regulation to Change Monthly Financial and Statistical Reporting

DRAFT STAFF RECOMMENDATION

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

October 9, 2013

These draft recommendations are for Commission consideration at the October 9, 2013 Public Commission Meeting. No action is required. Public comments should be sent to Dennis Phelps at the above address or by e-mail at Dennis.Phelps@Maryland.gov. For full consideration, comments must be received by October 25, 2013.

Background

Maryland hospitals under the jurisdiction of the HSCRC submit monthly financial and utilization data ("Monthly Reporting Data") to the HSCRC per COMAR 10.37.01.03. These data currently are submitted in an electronic format. These data are required to be submitted within 30 days of the last day of each month. The monthly data are used for a number of purposes including monitoring financial performance, monitoring rate compliance, Medicare waiver monitoring, and the annual rate adjustment. HSCRC has begun to implement processes to transition to population based revenue management and cost evaluation. In preparation for population based revenue compliance measurement, we must separate revenues and volumes for Maryland residents from those outside the State. This requires that encounters and related charges be separated into in-state and out-of-state categories to enable tracking of revenue and utilization based on patient origin. Additionally, HSCRC needs to obtain better data for monitoring of Medicare revenue trends on a monthly basis and will require the same breakouts for Medicare revenues and utilization.

Revising Monthly Data Submissions for Calendar 2014

For these reasons, HSCRC staff is proposing an amendment to COMAR 10.37.01.03 to change the Monthly Reporting Data to include revenue and utilization breakouts for out-of-state and Medicare patients in the monthly reporting effective January 1, 2014.

These data should be submitted as they are currently; however, the electronic format is being updated, and testing will begin with hospitals in October.

Historic Financial Data Submissions for July 1, 2012 through December 31, 2013

As the proposed expanded monthly submission would begin effective January 1, 2014, HSCRC will need similar monthly data for an 18 month historic period to enable comparisons to the base year. These data will be used to permit monitoring of actual results for the current period to the base period experience on a monthly and year-to-date basis. Hospitals will provide monthly data for the fifteen months From July 1, 2012 through September 30, 2013 to the hospitals in the expanded format by November 15. October through December 31, 2013 data should be submitted by January 31, 2014.

Technical Issues

The primary source of data for residency is zip code data. The zip code for international patients is 77777 (Foreign); however, HSCRC is aware that some international patients use local zip codes for billing. In these instances, hospitals will need to ensure that data associated with these international patients are reported as out-of-state. In addition, immigrants who are

residents of the United States should be reported as residents of the state in which they are currently residing. HSCRC will work with hospitals to address patients with no listed zip code. CRISP data can be used to find street addresses and locations where necessary.

Description	Dates Covered	Due Date
Monthly financial and utilization expansion to include break-out of residents from out-of-state patients, in total and for Medicare	From January 1, 2014 and ongoing	30 days after the end of each month
Historic monthly data (same as above).	July 1, 2012 through September 30, 2013	November 15, 2013
Historic monthly data (same as above).	October 1, 2013 through December 31, 2013	January 31, 2014

Hospital Input

HSCRC has been seeking hospital input during the development process. HSCRC will also provide content examples to hospitals.

Recommendations

Staff recommends the following:

1) Amend COMAR 10.37.01.03 to require hospitals to submit additional monthly hospital financial and utilization data, breaking out Maryland residents from out-of-state patients and providing a breakout of Medicare patients.
2) That HSCRC and the hospitals work together to develop monthly breakouts and reconciliations of FY 2013 data, and Quarters 1 and 2 of FY 14 data.

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

FINAL STAFF RECOMMENDATION

October 9, 2013

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

This final recommendation was approved by the Commission at the October 9, 2013 Public Meeting.

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. HSCRC staff is proposing amendments 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.

Purpose of Change

The case mix data feed into a number of methodologies. The current submission schedule has created delays in the Commission's ability to produce annual rate orders, monitor revenue, 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 (i.e., readmissions and Maryland Hospital Acquired Conditions (MHACS)) 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 communities as well.

Amending Case Mix Data Submissions from Quarterly to Monthly

HSCRC staff is proposing amendments to COMAR 10.37.04.01 and 10.37.06.01 to change the quarterly inpatient and outpatient data submissions to monthly submissions, effective with all discharges on or after 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.

Monthly submissions will be cumulative, up to three months, to allow hospitals to update data from previous months within the same quarter. Thus, hospitals will be submitting data as follows:

- Month 1 of quarter
- Months 1 and 2 of quarter together, then
- Months 1, 2, and 3 of quarter together (this is analogous to the preliminary data submissions)

To provide necessary time for hospitals to prepare the data submission, staff proposes to implement monthly data submission for FY 2014 Q3 and Q4 as follows:

Month-Ending Data	Proposed Due Date
January and February 2014	March 17th*
Updated January, February and March	April 15th
April	May 15th
Updated April and May	June 16th
Updated April, May and June	July 15th

*If the due date is on a weekend or State holiday, data is due the following business day.

The final due dates will be posted on the HSCRC website. A draft production schedule for FY 2014 is detailed below in Table 1.

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.

Revising the Final Case Mix Data Submission Due Date for Q2 FY 2014

As the proposed monthly submission is to be effective with discharges on or after January 1, 2014, collection of FY14 Q2 data needs to be aligned with the new timelines. Staff is requiring hospitals to submit final inpatient (including chronic and psychiatric datasets) and outpatient Q2 FY 2014 data to the Commission within 60 after the end of the quarter (instead of 90 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 March 2014. The exact due dates for data submissions will be posted on the Commission website. A draft production schedule for FY 2014 is detailed below in Table 1.

Table 1: DRAFT FY 2014 Production Schedule	End date	Case Mix Due Date
1st. Qtr (July-Sept)	9/30/2013	
1st Qtr Prelim		**12/2/2013**
Preliminary Rate Center Reconciliations Due		**12/9/2013**
1st Qtr Final		**12/27/2013**
Final Reconciliations Due		**1/3/2014**
2nd. Qtr (Oct.-Dec)	12/31/2013	
2nd Qtr Preliminary		**2/14/2014**
Preliminary Reconciliations Due		**2/21/2014**
2nd Qtr Final		**3/3/2014**
Final Reconciliations Due		**3/10/2014**

Table 1: DRAFT FY 2014 Production Schedule	End date	Case Mix Due Date
January 2014 data	1/31/2014	
January Preliminary		
Feb 2014 data	2/28/2014	
January & February Preliminary		**3/17/2014**
Mar 2014 Data	3/31/2014	
January, February & March Preliminary		**4/15/2014**
3rd Qtr (Jan-Mar)	3/31/2014	
3rd Qtr Final		**5/30/2014**
3rd Qtr Final Rate Center Reconciliations Due		**6/6/2014**
April 2014 data	4/30/2014	
April Preliminary		**5/15/2014**
May 2014 data	5/30/2014	
April & May Preliminary		**6/16/2014**
June 2014 data	6/30/2014	
April, May & June Preliminary		**7/15/2014**
4th Qtr (Apr - Jun)	6/30/2014	
4th Qtr Final		**8/29/2014**
4th Qtr Final Rate Center Reconciliations Due		**9/5/2014**

Vetting with the Hospital Industry

Staff is cognizant that this proposal will be a significant change for the hospital industry. The need for more timely data needs to be balanced with time and resources required to submit correct data. HSCRC staff communicated with several hospitals representing urban, rural, systems and small community hospitals in an effort to assess the feasibility of moving to monthly submission. In addition, the industry provided comment to the draft recommendation presented at the September 4, 2013 public meeting.

The industry's response to monthly reporting of the case mix data has been positive; however, hospitals cited two areas of concern, related to the FY 2014 production schedule, which are described below:

- *Compressed timeframe of final quarterly submissions*
  In August, staff verbally communicated to hospitals the intent to move to final data submission to be due within 35 days after the end of the quarter to align it with the monthly submission schedule. Hospitals expressed concern that data received in the shortened timeframe will not be complete. Hospitals typically allow physicians 30 days to complete their documentation, and then audit the records to ensure accurate coding.

Reducing the time between the due date and the end of the quarter to 35 days would greatly impact the accuracy of the data.

- *Reconciliations between case mix data and financial data*
  Currently, hospitals reconcile the case mix data to the financial data by rate center on a quarterly basis (coinciding with the preliminary and final data submissions). This reconciliation is very detailed and time consuming. Hospitals expressed concern that this level of reconciliation is not feasible on a monthly basis.

In response to the industry's concerns, HSCRC staff has revised the due dates for the final quarterly submissions, extending them from 35 days to 60 days after the end of the quarter. Although monthly submissions will be considered preliminary submissions, HSCRC staff urges hospitals to streamline the coding and auditing of the records to provide accurate information with monthly submissions, which should lessen the time required to clean final quarterly data.

With regard to the reconciliations between case mix and financial data, staff is amenable to reducing the required rate center level reconciliation to once a quarter, and providing hospitals with reports reconciling case mix to the financial data on a monthly basis. Staff will continue to discuss the reconciliation reporting with hospitals as staff refines their reporting needs.

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.

Maryland
Hospital Association

MHA
6820 Deerpath Road
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Tel: 410-379-6200
Fax: 410-379-8239

September 20, 2013

Claudine Williams
Associate Director, Policy Analysis
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215-2299

Dear Claudine:

On behalf of the 66 members of the Maryland Hospital Association (MHA), we appreciate the opportunity to comment on the Health Services Cost Review Commission (HSCRC) recommendations to *Amend Regulation to Move Inpatient and Outpatient Data Submissions from Quarterly to Monthly* presented at the September 4 public meeting. The draft recommendation speaks to shorter timeframes for submission of *preliminary* case mix data, but is silent on HSCRC's plan to also shorten timeframes for submission of final case mix data and related spreadsheets reconciling case mix and financial data. It is the final submission timeframes and the reconciliation requirements that most concern hospitals, and based on informal discussions with HSCRC staff, the area on which HSCRC and hospitals' expectations are not aligned.

While **MHA supports monthly collection of preliminary case mix data for the reasons outlined in the draft recommendation, we strongly oppose the recommendations staff have verbally communicated to shorten the timeframe for submission of final data from the current approximate 90 days to 35 days after the end of the quarter**. Hospitals use the time between the preliminary and final submissions to finalize coding and ensure that it is as accurate and complete as possible. This may include waiting for a lab result, ensuring documentation is complete and clear, and asking questions to understand whether medical conditions were present on admission.

Accurate coding of diagnoses and whether they were present on admission is the foundation of the HSCRC's Maryland Hospital-Acquired Conditions (MHAC) program--a methodology that puts at risk up to three percent of a hospitals' inpatient revenue. Such an unreasonable shortening of the time hospitals need to make sure their submissions are accurate undermines the legitimacy of the MHAC program. The Medicare program allows providers up to 12 months to resubmit coding changes. Moreover, hospitals' medical staff by-laws typically provide physicians up to 30 days to complete the medical record. Requiring final data five days after the chart is complete would leave no time for review and barely enough time to even prepare and run the data for submission.

The draft staff recommendation is also silent on changes to the requirement to submit data and explanations reconciling the financial and case mix data. Financial and case mix data may not exactly match because case mix data includes cases based on the date of service and financial

-more-

data includes cases based on when claims are submitted for payment. Most of the time, the dates of service and claims activity coincides, particularly in the aggregate. However, there are reasons why the two data sets do not perfectly match such as when outpatient charges must be bundled onto the inpatient claim and when "late" charges are submitted after the bill sent at discharge.

These mismatches become more frequent as the shortened time period narrows the slice of activity in the reports. Currently, the HSCRC requires a reconciliation at the unit rate level every quarter--a requirement that became necessary as the HSCRC attempted to implement the outpatient Charge-per-Visit methodology. It is unclear that this level of detail is still necessary. **MHA recommends the HSCRC reconcile case mix and financial data in the aggregate each quarter and stop requiring a reconciliation at the unit rate level**.

At a time when hospitals are already asking their employees to do more with less, we urge you to thoughtfully consider the enormous administrative burden a drastically shortened final case mix submission date would create and to also consider scaling back the reconciliation requirements. I appreciate your consideration of our comments and would be happy to respond to any questions. I can be reached at 410-379-6200.

Sincerely,

Traci La Valle

Traci La Valle
Vice President, Financial Policy & Advocacy
Maryland Hospital Association

cc: Donna Kinzer
Commissioners, HSCRC

Adventist HealthCare

820 W. Diamond Avenue, Suite 600
Gaithersburg, Maryland 20878
Office: 301-315-3030
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September 23, 2013

Claudine Williams
Associated Director, Policy Analysis
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215-2299

Dear Claudine,

On behalf of Adventist HealthCare Inc. (AHC), Shady Grove Adventist Hospital, Washington Adventist Hospital, Adventist Behavioral Health, and Adventist Rehabilitation Hospital of Maryland, we appreciate the opportunity to comment on the Health Services Cost Review Commission (HSCRC) recommendations to *Amend Regulation to Move Inpatient and Outpatient Data Submissions from Quarterly to Monthly* presented at the September 4 public meeting. It is our understanding the intent of this change is to provide information in a timely manner to provide greater predictability and more real-time monitoring. While we appreciate this objective, we are concerned that the dramatically shortened time lines will jeopardize the accuracy and completeness of data the HSCRC requires while adding additional administrative burden to the hospitals.

AHC believes that one of the most important factors to consider in evaluating this recommendation is the ability to collect complete and accurate data. While submitting data on a monthly basis will provide the HSCRC with data more frequently and timely, we are concerned about the accuracy of this data at the time of submission as well the accuracy of the final quarterly submission with a significantly compressed quarterly timeline. Currently, Shady Grove Adventist Hospital and Washington Adventist Hospital have external auditors reviewing inpatient claims for coding accuracy. These audits typically occur 30 days after the month of discharge giving the physicians the necessary time to complete their documentation prior to review. Shortening the timeline for submission to 35 days, which has been verbally communicated by the staff, will dramatically impact the process, leaving little time to review records for accurate coding, process the tape run, correct errors, reprocess and submit. Additionally, this change will probably require additional resources year round to keep up with this schedule and maintain the integrity of the data. These additional resources will be required to meet not only the revised tape timelines, but also keep up with the various quality initiatives, such as MHAC and QBR, currently in place. We would like to request the HSCRC to reconsider a balance between the objectives of timely data submission and ensuring accurate and complete data. As such, we request the HSCRC reconsider its position on shortening the quarterly data submission to 35 after the end of each quarter and keep the quarterly submission timeline as is while moving to monthly preliminary submissions.

The second area of concern is with the current reconciliation process. Currently, all hospitals in Maryland submit 2 tapes each quarter, a "preliminary" tape data which is due within 60 days after the end of the quarter, and a "final" tape data which is due within 90 days after the end of the

quarter. In addition to the tape submissions, each hospital is required to submit rate center level reconciliations between the financial data and case-mix data for both the preliminary and final submissions. These reconciliations are already a cumbersome process at eight times per year per hospital. AHC believes that this level of detail reconciliation on both a monthly and quarterly basis would be administratively burdensome without adding any additional value. As such, we would like to request that the HSCRC abandon the requirement to reconcile the preliminary submissions at a detailed unit rate level.

On behalf of AHC, we would like to thank you for giving us this opportunity to share our concerns regarding the staff draft recommendations outlined in the draft recommendation to *Amend Regulation to Move Inpatient and Outpatient Data Submissions from Quarterly to Monthly* presented at the September 4 public meeting. I hope we have clearly explained our concerns, and welcome any and all questions you may have.

Sincerely,

Kristen Pulio
Associate Vice President, Reimbursement

cc: Donna Kinzer, Health Services Cost Review Commission
Commissioners, Health Services Cost Review Commission

BON SECOURS BALTIMORE HEALTH SYSTEM

Katie Eckert
Director, Budget & Reimbursement
Bon Secours Baltimore Health System
2000 West Baltimore Street
Baltimore, Maryland 21223
September 19, 2013

Claudine Williams
Associate Director, Policy Analysis
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Claudine:

We are responding to the request to provide feedback on the Health Services Cost Review Commission (HSCRC) recommendations regarding a monthly abstract data tape submission and reconciliation process. We have concerns regarding the completeness of the data in the timeframes requested as well as the purpose of collecting this information.

Our chief concern regards the completeness of the data in the timeframe requested. Currently, we have approximately 90 days after the end of a quarter for the final submission of abstract tape data. At the September 13, 2013 Financial Technical Issues Task Force Meeting (FTITF), HSCRC Staff recommended reducing the timeframe to submit final abstract tape data to 35 days. This is a radical change from a Hospital operations perspective.

We primarily use this time to ensure completeness of the medical record since our medical staff by-laws permit physicians up to 30 days to finalize the medical record. Furthermore, additional medical record documentation as it relates to the HSCRC's Maryland Hospital Acquired

Conditions (MHAC) is completed during this time. Reducing the timeframe to submit final abstract data by 55 days severely compromises our ability to report complete data.

We are also concerned about the purpose of collecting the abstract tape data on preliminary, monthly basis. Our understanding from HSCRC Staff comments at the September 13, 2013 FTITF is that the Staff's goal is to monitor the State's compliance with the new Waiver. However, the Staff stated that they did not know how they were going to use the data to monitor compliance.

Our concern is that in order to produce meaningful analytics it is critical to take into consideration the completeness of the data elements involved. While demographics and charges are typical finalized within a 30 day window, APR-DRG and severity-of-illness components can change significantly from initial coding to final review as the medical record is completed and reviewed for accuracy. Monthly abstract tape data will not provide complete enough case-mix data in order to do meaningful analysis related to monitoring the Waiver because these data elements will not be complete within a 30 day timeframe.

From a hospital operations perspective the only way to produce final records in a shorter timeframe is to increase manpower devoted to ensuring medical record completeness. This would compete with the already stretched resources we also need to devote to transitioning to ICD-10.

Additionally, the HSCRC staff recommended monthly case-mix reconciliations to coincide with the new monthly submission. Even reconciliations in the aggregate would be difficult since variance analysis would require a drill down at the rate center level.
We are concerned about this massive devotion of resources towards a purpose that has not been clarified.

We support the collection of monthly abstract data elements in order for HSCRC Staff to be able to monitor new Waiver requirements. However, our recommendation is that the data elements be identified and vetted for accuracy prior to requesting mass data submissions.

The Hospital industry can provide critical information about processes and timeframes necessary for data completeness. When we are dealing with live patient databases there is often a difficult compromise between completeness and timeliness. We believe that the collaborative efforts of the FTITF, MHA and HSCRC Staff can meet the needs of monitoring the new Waiver while ensuring timely, accurate data without extreme administrative overhead requirements.

Sincerely,
Bon Secours Baltimore Health System, Inc.

Richard L. Jones
Chief Financial Officer

Katie Eckert
Director, Budget & Reimbursement

Donna Fortson
Director, Revenue Cycle

HOLY CROSS HEALTH

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September 23, 2013

Claudine Williams
Associate Director, Policy Analysis
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215-2299

Dear Ms. Williams,

I am writing to support the Maryland Hospital Association (MHA) position on the recent Maryland Health Services Cost Review Commission (HSCRC) recommendation to change inpatient and outpatient data submission deadlines beginning in CY 2014. We are deeply concerned about the HSCRC staff suggestion to shorten the timeframe for submission of final data from 90 days to 35 days after the end of each quarter.

We appreciate the quality-driven rate setting policies that HSCRC has instituted in the state of Maryland as exampled by the Maryland Hospital Acquired Conditions (MHAC) program. To accurately reflect the quality of care that we provide, medical record documentation and coding must both be accurate and complete. The Joint Commission does not require records to be closed until 30 days post discharge and the Holy Cross Hospital Medical Staff by-laws follow that standard. We strive to perform timely preliminary coding of medical records and often accomplish this within a few days of a patient's discharge. However, with additional documentation and our program of quality audits, it takes considerably longer to finalize record coding.

Our systems are designed to meet the current schedule of final submission 90 days after the end of a quarter and we are often stretched to meet that timetable. We are concerned that shortening the timeframe for final data submission will jeopardize the coding accuracy for at least the last month of each quarter, resulting in suspect data submission for a third or more of each year. In addition to placing up to 3% of the hospital's annual reimbursement at undue risk with MHACs, the early submission threatens to inaccurately (and poorly) portray hospital care quality performance across the state of Maryland. This will be highlighted in the CMS Hospital Acquired Conditions (HACs) reporting. HACs are very dependent on Present on Admission (POA) flagging and seem likely to be scrutinized as a quality metric for a changed Medicare waiver.

We understand that there is new priority for near real time data to support some of the accountable care initiatives that will be a part of a new waiver. Knowing when and where patients have contact with hospitals across the state will be essential and only current data will be truly actionable. For this reason, we support monthly submission of preliminary data.

We are all aware of the fast-approaching adoption of ICD-10 in October 2014 and that it will significantly challenge documentation and coding efforts from the start of the year. The newly proposed more stringent timeframe for finalizing coding submissions, on top of ICD-10 compliance efforts, will likely have a dramatic impact on many, if not all, of the state's hospitals.

Lastly, 2014 will present unique challenges to Holy Cross Health, as we open a new acute care hospital in Germantown. We worry that the compressed data submission deadline will adversely affect the portrayal of this new hospital's quality performance and so jeopardize its financial performance.

Holy Cross Health is not alone as it strives to provide excellent health care and then accurately portray that quality in a record that is as completely and accurately documented and coded as possible. As such, we stand with MHA and the other Maryland hospitals in urging HSCRC to maintain the reasonable current standard of allowing approximately 90 days after the close of a quarter before final data submission is required.

Sincerely,

Yancy Phillips, MD, MACP
Chief Quality Officer

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3910 Keswick Road
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JOHNS HOPKINS
MEDICINE
JOHNS HOPKINS
HEALTH SYSTEM

September 23, 2013

Claudine Williams
Associate Director, Policy Analysis
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215-2299

Dear Ms. Williams:

I am writing on behalf of the Johns Hopkins Health System (JHHS) 4 Maryland hospitals (The Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, Howard County General Hospital and Suburban Hospital Center). We appreciate the opportunity to comment on the Health Services Cost Review Commission (HSCRC) recommendation to *Amend Regulation to Move Inpatient and Outpatient Data Submissions from Quarterly to Monthly* presented at the September 4, 2013 public meeting.

JHHS supports the monthly submission of preliminary case-mix data for the reasons outlined in the draft recommendation. We understand the need for more timely reporting for monitoring purposes under the proposed new waiver. However, we strongly oppose the recommendation staff have verbally communicated to shorten the time frame for submission of the final case-mix data from the current 90 days to 35 days after the end of the quarter. Hospitals utilize the time between the preliminary and final submissions to assure that coding is as accurate and complete as possible. Since these final submissions are utilized for quality measures which put up to 3% of a hospital's inpatient revenue at risk, it is important that this data be as accurate and complete as possible.

We would also like to request that the commission consider discontinuing the detailed rate center level reconciliation of case-mix data to financial statistical and revenue data submitted by the hospitals. This reconciliation was originally put in place during the implementation of the charge per visit (CPV) methodology, which no longer exists. These detailed reconciliations take a considerable amount of time to complete on a quarterly basis and to my knowledge are not used for anything in the rate setting system. We think that it is reasonable to have hospitals reconcile case-mix and financial data in the aggregate each quarter.

I appreciate your consideration of our comments and would be happy to respond to any questions you may have about them. I can be reached at 443-997-0631 or jberane1@jhmi.edu.

Sincerely,

Ed Beranek
Director of Regulatory Compliance
Johns Hopkins Health System

Cc: Donna Kinzer

LIFEBRIDGE
HEALTH

Sinai Hospital
Northwest Hospital
Levindale Hebrew Geriatric Center and Hospital
Courtland Gardens Nursing & Rehabilitation Center

Septemter 23, 2013

Claudine Williams
Associate Director, Policy Analysis
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215-2299

Dear Claudine:

LifeBridge Health appreciates the opportunity to comment on the Health Services Cost Review Commission (HSCRC) recommendations to *Amend Regulation to Move Inpatient and Outpatient Data Submissions from Quarterly to Monthly* presented at the September 4 public meeting.

The draft recommendation speaks to shorter timeframes for submission of *preliminary* case-mix data. Our concern for shorter time frames for preliminary data begins with how accurate the data will be on a monthly basis. Would a subset of data be a better alternative? Until we start to run the data monthly you will not know the volume of incomplete data that you are receiving from hospitals. This request may also require our vendors change some of the programming to allow all of the data to flow to the tapes. All accounts do not automatically flow to the tapes; many account types need manual intervention to complete the flow. We are also concerned about a possible increase in workload to reconcile the data to the financial information. The reconciliation is a daunting task on a quarterly basis, monthly could prove to be unreasonable.

While not mentioned in the draft recommendation, it was discussed in at the MHA Technical Issues Task Force on September 12, to shorten the timeframe for submission of *final* data from the current approximate 90 days to 35 days after the end of the quarter. We use the time between the preliminary and final submissions to finalize coding and ensure that it is as accurate and complete as possible. We are working on entering information until the last day possible, as it continues to be accumulated in Health Information Management department. Accurate data continues to be updated even after the tapes are final. Another concern is that our bi-laws require that physicians complete their medical record documentation in a 30 day timeframe. If the physicians are allowed a 30 day window, we respectfully request that the hospital be given more time.

At a time when hospitals are already asking their employees to do more with less, we urge you to thoughtfully consider the enormous administrative burden these changes would create.

Sincerely,

David Krajewski
Sr. Vice President / CFO, LifeBridge Health

cc: Donna Kinzer
Commissioners, HSCRC

MedStar Health

8010 Suite O Corporate Dr.
Nottingham, MD 21236
410-933-2300 **PHONE**
medstarhealth.org

September 24, 2013

Claudine Williams
Associate Director, Policy Analysis
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215-2299

Dear Claudine:

On behalf of the seven MedStar Maryland Hospitals, we appreciate the opportunity to comment on the Health Services Cost Review Commission (HSCRC) recommendations to *Amend Regulation to Move Inpatient and Outpatient Data Submissions from Quarterly to Monthly* presented at the September 4 public meeting.

While monthly collections will provide you with some additional data not already collected monthly that might be useful in the new waiver monitoring, there is still a need to allow for changes prior to the finalization of data. Medicare, Medicaid, and other payers across the country leave their data systems open for 12 months or longer to allow for capturing of revised billing detail to ensure the data is complete. Many of their reimbursement programs have prospective adjustments (i.e. readmissions) or settle-ups (i.e. cost reports) based on this historical data. The HSCRC current provisions is already much shorter and does not account for all billing changes. Further reductions will not provide Hospitals adequate time necessary and will further build a disconnect between the HSCRC data and the billing data for all payors. We believe we need to spend time to develop a process that better aligns with other data supplied by Medicare and other payors.

We support the letter submitted by Maryland Hospital Association that:

- **Opposes the recommendations staff have verbally communicated to shorten the timeframe for submission of final data from the current approximate 90 days to 35 days after the end of the quarter; and**
- **Recommends the commission reconcile case-mix and financial data in the aggregate each quarter and stop requiring a reconciliation at the unit rate level.**

I appreciate your consideration of our comments and would be happy to address any questions you may have. I can be reached at 410-933-2375.

Sincerely,

Kathy Talbot

Kathy Talbot, Vice President, Rates and Reimbursement
MedStar Health

cc: Donna Kinzer, Acting Executive Director, Health Services Cost Review Commission
Commissioners, HSCRC
Michael Curran, Corporate, EVP, Chief Administrative & Financial Officer
CFOs, MedStar Health

UNIVERSITY of MARYLAND MEDICAL SYSTEM

Finance Shared Services

250 W Pratt Street, 14th Floor
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410-328-3645 | 410-328-3501 FAX
umm.edu

September 24, 2013

Ms. Claudine Williams
Associate Director, Policy Analysis
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

RE: UMMS - Comments to HSCRC DRAFT Staff Recommendation September 4, 2013 – *Amend Regulation to Move Inpatient and Outpatient Data Submissions from Quarterly to Monthly*

Dear Ms. Williams:

On behalf of the University of Maryland Medical System (UMMS) and its thirteen hospitals, we appreciate the opportunity to comment on HSCRC DRAFT Staff Recommendation September 4, 2013 – *Amend Regulation to Move Inpatient and Outpatient Data Submissions from Quarterly to Monthly*.

UMMS supports the timely data needs of the Commission and is supportive of the three draft recommendations to submit monthly preliminary abstract data with two caveats:

1) The HSCRC must recognize that this is preliminary coded patient level data and should only be utilized to gather volume and revenue information. We do not recommend the monthly data be used for calculating case-mix since the coding has not gone through the normal internal or external review processes; and

2) The HSCRC recognize that it will continue to take upwards of 90 days for hospitals to finalize the data.

Specifically, in reference to caveat two above, we are concerned to learn through further discussions with HSCRC Staff after the September Commission meeting, that there is an unwritten implication of the Staff Recommendation to shorten the timeframe for submitting final data from 90 days to 35 days after the end of the quarter. This was not our understanding in any previous conversations we had with HSCRC Staff.

UMMS strongly opposes a change to the 90 day timeframe to finalize the quarterly data. This change poses unfavorable permanent rate adjustments due to inconsistent quality of data for multiple HSCRC methodologies and programs. The following issues should be considered in regards to this proposal:

1. Both financial and clinical data can change well beyond 35 days of patient discharge. For example, payor assignment may change as a result of a change in status from acute to chronic up to 45 days after discharge. Additionally, clinical documentation is reviewed and vetted

with physicians to insure accurate coding of diagnoses, procedures and present on admission flags.

2. A shortened timeline is counterproductive to efforts for improving and maintaining the quality of abstract data. As both revenue implications and the reliance on abstract data have continued to increase (e.g. MHAC, QBR-Risk of Mortality), hospitals have invested resources and implemented work flows to review and audit records differently to ensure greatest levels of accuracy possible. These efforts have occurred over time and have relied on the stability of the HSCRC's production schedule.

3. A significant amount of process reengineering would be necessary and would demand an increase in hospital staffing resources, including coding, clinical documentation improvement, auditing, patient financial services and patient registration functions at a time when funding is just not available.

4. The impending, ICD-10 implementation is demanding a large amount of hospital resources, specifically in coding and documentation functions. Shifting scarce resources from the ICD10 project to implement new HSCRC reporting timelines would not be prudent. Additionally, it will require every bit of 90 days to ensure the quality of the abstract data remains consistent after the October 1, 2014 ICD10 go-live.

UMMS also maintains concerns regarding the requirement for reconciliation of Case Mix and Financial data at the unit rate level. This requirement is an arduous effort and will impose significant administrative effort to complete with monthly submissions. UMMS requests HSCRC staff assess the frequency, data element needs, and value of these reconciliations with respect to staff needs in light of its origin from the now-obsolete Charge per Visit methodology. UMMS recommends the following:

1. Hospitals reconcile Case Mix and Financial data in the aggregate only for the monthly preliminary submissions; and

2. For the quarterly final submissions, hospitals reconcile Case Mix and Financial data in aggregate, but perform rate center reconciliations for rate centers identified as key concerns for HSCRC policies and methodologies.

Thank you for your time and consideration of UMMS' comments. Feel free to contact me at (410) 328-1380 for further discussion.

Sincerely,

Alicia Cunningham

Alicia Cunningham
Vice President
Reimbursement & Revenue Advisory Services

Cc Henry Franey, UMMS

UNION HOSPITAL

KENNETH S. LEWIS M.D., J.D.
President and Chief Executive Officer

September 26, 2013

Claudine Williams
Associate Director, Policy Analysis
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215-2299

Dear Ms. Williams.

On behalf of Union Hospital of Cecil County, I appreciate the opportunity to comment on the Health Services Cost Review Commission (HSCRC) recommendations to *Amend Regulation to Move Inpatient and Outpatient Data Submissions from Quarterly to Monthly* presented at the September 4 public meeting. The draft recommendation speaks to shorter timeframes for submission of *preliminary* case-mix data, but is silent on HSCRC's plan to also shorten timeframes for submission of final case-mix data and related spreadsheets reconciling case-mix and financial data. It is the final submission timeframes and the reconciliation requirements that most concern us, and based on informal discussions with HSCRC staff are the areas on which HSCRC and hospitals' expectations are not aligned.

We strongly oppose the recommendations staff have verbally communicated to shorten the timeframe for submission of final data from the current approximate 90 days to 35 days after the end of the quarter. Hospitals use the time between the preliminary and final submissions to finalize coding and ensure that it is as accurate and complete as possible. This may include waiting for a lab result, ensuring documentation is complete and clear, and asking questions to understand whether medical conditions were present on admission.

Accurate coding of diagnoses and whether they were present on admission is the foundation of the HSCRC's Maryland Hospital Acquired Conditions (MHAC) program—a methodology that puts at risk up to 3 percent of a hospitals' inpatient revenue. Such an unreasonable shortening of the time hospitals need to make sure their submissions are accurate undermines the legitimacy of the MHAC program. The Medicare program allows providers up to 12 months to resubmit coding changes. Union's medical staff by-laws provide physicians up to 30 days to complete medical records. Requiring final data five days after the chart is complete would leave no time for review and barely enough time to even prepare and run the data for submission.

The draft staff recommendation is also silent on changes to the requirement to submit data and explanations reconciling the financial and case-mix data. Financial and case-mix data may not exactly match because case-mix data includes cases based on date of service and financial data includes cases based on when claims are submitted for payment. Most of the time, the dates of

106 Bow Street • Elkton, Maryland 21921 • Direct: 410/392-7009 • Fax: 410/620-1494

service and claims activity coincide, particularly in the aggregate. However, there are reasons why the two data sets do not perfectly match such as when outpatient charges must be bundled onto the inpatient claim and when "late" charges are submitted after the bill sent at discharge.

These mismatches become more frequent as the shortened time period narrows the slice of activity in the reports. Currently, the commission requires a reconciliation at the unit rate level every quarter--a requirement that became necessary as the commission attempted to implement the outpatient charge per visit methodology. It is not clear that this level of detail is still necessary.

At a time when hospitals are already asking their employees to do more with less, we urge you to thoughtfully consider the enormous administrative burden a drastically shortened final case-mix submission date would create and to also consider scaling back the reconciliation requirements. I appreciate your consideration of our comments.

Sincerely,

Kenneth S. Lewis, M.D., J.D.
President and Chief Executive Officer

Title 10 DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Subtitle 37 HEALTH SERVICES COST REVIEW COMMISSION

Chapter 04 Submission of Hospital Outpatient Data Set to the Commission

Authority: Health-General Article, §§19-207, 19-212, 19-215, and 19-216, Annotated Code of Maryland

Notice of Emergency Action

The Health Services Cost Review Commission has granted emergency status to amend Regulation .01 under COMAR 10.37.04 Submission of Hospital Outpatient Data Set to the Commission.

Emergency Status Begins: January 1, 2014

Emergency Status Expires: March 1, 2014

Comparison of Federal Standards

There is currently no corresponding federal standard to this proposed action.

Comparison to Federal Standards

There is no corresponding federal standard to this proposed action.

Estimate of Economic Impact

See attachment.

.01 Collection and Submission of Data.

A. Effective [February 1, 2009,] *January 1, 2014*, each hospital under the jurisdiction of the Health Services Cost Review Commission (Commission) shall submit the data elements as published in the Maryland Register and on the Commission's website [(http://www.hscrc.state.md.us)] *(http://www.hscrc.maryland.gov)* to the Commission within [60] *15* days following the last day of the [quarter] *month* during which the patient was discharged or died. The format for submission shall also be as published in the Maryland Register and on the Commission's website.

B. (text unchanged)

.02-.05 (text unchanged)

John M. Colmers
Chairman
Health Services Cost Review Commission

Estimate of Economic Impact

PART A

I. Summary of Economic Impact.

Hospitals will be required to submit outpatient data monthly, instead of quarterly. Monthly data submissions will improve HSCRC staff's ability to monitor population based metrics (including readmissions and MHACs) as well as approved revenue under population-based models on an ongoing basis.

II. Types of Economic Impact	Expenditure (E+/E-)	Revenue (R+/R-) Magnitude
A. On issuing agency:	E+	$135,000
B. On other State agencies:	NONE	
C. On local governments:	NONE	

	Cost(-) Benefit(+)	Magnitude
D. On regulated industries or trade groups:	(-)	Moderate
E. On other industries or trade groups:	NONE	
F. Direct and indirect effects on public:	NONE	

III. Assumptions. (Identified by Impact Letter and Number from Section II.)

A. These regulations increase the number of required submissions from hospitals. The magnitude reflects the increase in the cost to the data vendor to process the additional submissions.

D. This regulatory change accelerates the time for submission of monthly patient-level outpatient data from 60 days to 15 days, improving the ability of HSCRC staff to monitor, produce annual rate orders, and provide feedback to hospitals in a timely manner. This change is highly desired by the payer and provider communities as they develop and implement care intervention strategies. Although many hospitals already produce their case mix data on a monthly basis for internal purposes, there may be a moderate economic impact on the hospitals to produce the monthly case mix data for the HSCRC.

PART B

Economic Impact on Small Business

X The proposed action has minimal or no economic impact on small businesses

Or

___ The proposed action has a meaningful economic impact on small businesses. An analysis of this economic impact follows.

Impact on Individuals with Disabilities

X The proposed action has no impact on individuals with disabilities.

Or

___ The proposed action has an impact on individuals with disabilities as follows:

PART C

(For legislative use only, not for publication)

A. Fiscal Year in which regulations will become effective: 2014

B. Does the budget for fiscal year in which regulations become effective contain funds to implement the Regulations: N/A

_X_ Yes or ____ No

C. If "yes", state whether general, special (exact name), or federal funds will be used: Health Services Cost Review Commission fund

D. If "no", identify the source(s) of funds necessary for implementation of these regulations: N/A

E. If these regulations have no economic impact under Part A, indicate reason briefly: N/A

F. If these regulations have minimal or no economic impact on small business under Part B, indicate the reason:

Title 10 DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Subtitle 37 HEALTH SERVICES COST REVIEW COMMISSION

Chapter 04 Submission of Hospital Outpatient Data Set to the Commission

Authority: Health-General Article, §§19-207, 19-212, 19-215, and 19-216, Annotated Code of Maryland

Notice of Proposed Action

The Health Services Cost Review Commission proposes to amend Regulation **.01** under **COMAR 10.37.04** Submission of Hospital Outpatient Data Set to the Commission. This action was considered and approved for promulgation by the Commission at a previously announced open meeting held on October 9, 2013, notice of which was given pursuant to State Government Article, § 10-506(c), Annotated Code of Maryland. If adopted the proposed amendments will become effective on or about February 3, 2014.

Statement of Purpose

The purpose of this action is to require hospitals to submit monthly patient level outpatient visit data in the manner and format prescribed by the Commission, and to enable the Commission to fully monitor population-based metrics and approved revenue under population-based payment models. Additionally, these proposed regulations are to be effective on January 1, 2014 since they represent an essential component in the development and implementation of new rate regulatory approaches and policies that encompass quality and clinical care improvement elements.

Comparison to Federal Standards

There is no corresponding federal standard to this proposed action.

Estimate of Economic Impact

See attachment.

Opportunity for Public Comment

Comments may be sent to Diana M. Kemp, Regulations Coordinator, Health Services Cost Review Commission, 4160 Patterson Avenue, Baltimore, Maryland 21215, or via fax to (410) 358-6217, or via email to diana.kemp@maryland.gov. The Health Services Cost Review Commission will consider comments on the proposed amendments until December 2, 2013. A hearing may be held at the discretion of the Commission.

.01 Collection and Submission of Data.

A. Effective [February 1, 2009,] *January 1, 2014*, each hospital under the jurisdiction of the Health Services Cost Review Commission (Commission) shall submit the data elements as published in the Maryland Register and on the Commission's website [(http://www.hscrc.state.md.us)] *(http://www.hscrc.maryland.gov)* to the Commission within [60] *15* days following the last day of the [quarter] *month* during which the patient was discharged or died. The format for submission shall also be as published in the Maryland Register and on the Commission's website.

B. (text unchanged)

.02-.05 (text unchanged)

John M. Colmers
Chairman
Health Services Cost Review Commission

Estimate of Economic Impact

PART A

I. Summary of Economic Impact.

Hospitals will be required to submit outpatient data monthly, instead of quarterly. Monthly data submissions will improve HSCRC staff's ability to monitor population based metrics (including readmissions and MHACs) as well as approved revenue under population-based models on an ongoing basis.

II. Types of Economic Impact	Expenditure (E+/E-)	Revenue (R+/R-) Magnitude
A. On issuing agency:	E+	$135,000
B. On other State agencies:	NONE	
C. On local governments:	NONE	

	Cost(-) Benefit(+)	Magnitude
D. On regulated industries or trade groups:	(-)	Moderate
E. On other industries or trade groups:	NONE	
F. Direct and indirect effects on public:	NONE	

III. Assumptions. (Identified by Impact Letter and Number from Section II.)

A. These regulations increase the number of required submissions from hospitals. The magnitude reflects the increase in the cost to the data vendor to process the additional submissions.

D. This regulatory change accelerates the time for submission of monthly patient-level outpatient data from 60 days to 15 days, improving the ability of HSCRC staff to monitor, produce annual rate orders, and provide feedback to hospitals in a timely manner. This change is highly desired by the payer and provider communities as they develop and implement care intervention strategies. Although many hospitals already produce their case mix data on a monthly basis for internal purposes, there may be a moderate economic impact on the hospitals to produce the monthly case mix data for the HSCRC.

PART B

Economic Impact on Small Business

X The proposed action has minimal or no economic impact on small businesses

Or

___ The proposed action has a meaningful economic impact on small businesses. An analysis of this economic impact follows.

Impact on Individuals with Disabilities

X The proposed action has no impact on individuals with disabilities.

Or

___ The proposed action has an impact on individuals with disabilities as follows:

PART C

(For legislative use only, not for publication)

A. Fiscal Year in which regulations will become effective: 2014

B. Does the budget for fiscal year in which regulations become effective contain funds to implement the Regulations: N/A

_X_ Yes or ____ No

C. If "yes", state whether general, special (exact name), or federal funds will be used: Health Services Cost Review Commission fund

D. If "no", identify the source(s) of funds necessary for implementation of these regulations: N/A

E. If these regulations have no economic impact under Part A, indicate reason briefly: N/A

F. If these regulations have minimal or no economic impact on small business under Part B, indicate the reason:

Title 10 DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Subtitle 37 HEALTH SERVICES COST REVIEW COMMISSION

Chapter 06 Submission of Hospital Discharge Data Set to the Commission

Authority: Health-General Article, §§19-207, 19-211, 19-212, 19-215, and 19-216, Annotated Code of Maryland

Notice of Emergency Action

The Health Services Cost Review Commission has granted emergency status to amend Regulation .01 under COMAR 10.37.06 Submission of Hospital Discharge Data Set to the Commission.

Emergency Status Begins: January 1, 2014

Emergency Status Expires: March 1, 2014

Comparison of Federal Standards

There is currently no corresponding federal standard to this proposed action.

Estimate of Economic Impact

See attachment.

.01 Collection and Submission of Data.

A. [Unless an exception or an extension has been granted under §C of this regulation.] Beginning on January 1, 2014, each hospital under the jurisdiction of the Health Services Cost Review Commission shall submit to the Commission:

(1) The data elements required by this chapter within [45] *15* days after the last day of the [quarter] *month* when the patient was discharged or died; and

(2) (text unchanged)

B. Submission Requirements.

(1) The data elements submitted under §A(1) o this regulation shall be made in the form as published in the Maryland Register and on the Commission's website [http://hscrc.state.md.us] *http://hscrc.maryland.gov*.

(2) (text unchanged)

C.-D. (text unchanged)

.01-1-.05 (text unchanged)

JOHN M. COLMERS
Chairman
Health Services Cost Review Commission

Estimate of Economic Impact

PART A

I. Summary of Economic Impact.

Hospitals will be required to submit inpatient data monthly, instead of quarterly. Monthly data submissions will improve HSCRC staff's ability to monitor population based metrics (including readmissions and MHACs) as well as approved revenue under population-based models on an ongoing basis.

II. Types of Economic Impact	Expenditure (E+/E-)	Revenue (R+/R-) Magnitude
A. On issuing agency:	E+	$135,000
B. On other State agencies:	NONE	
C. On local governments:	NONE	

	Cost(-) Benefit(+)	Magnitude
D. On regulated industries or trade groups:	(-)	Moderate
E. On other industries or trade groups:	NONE	
F. Direct and indirect effects on public:	NONE	

III. Assumptions. (Identified by Impact Letter and Number from Section II.)

A. These regulations increase the number of required submissions from hospitals. The magnitude reflects the increase in the cost to the data vendor to processes the additional submissions.

D. This regulatory change accelerates the time for submission of monthly patient-level inpatient data submissions, from 45 days to 15 days, improving the ability of HSCRC staff to monitor, produce annual rate orders, and provide feedback to hospitals in a timely manner. This change is highly desired by the payer and provider community as they develop and implement care intervention strategies. Although many hospitals already produce their case mix data on a monthly basis for internal purposes, there may be a moderate economic impact on the hospitals to produce the monthly case mix data for the HSCRC.

PART B

Economic Impact on Small Business

X The proposed action has minimal or no economic impact on small businesses

Or

___ The proposed action has a meaningful economic impact on small businesses. An analysis of this economic impact follows.

Impact on Individuals with Disabilities

X The proposed action has no impact on individuals with disabilities.

Or

___ The proposed action has an impact on individuals with disabilities as follows:

PART C

(For legislative use only, not for publication)

A. Fiscal Year in which regulations will become effective: 2014

B. Does the budget for fiscal year in which regulations become effective contain funds to implement the Regulations: N/A

X Yes or ____ No

C. If "yes", state whether general, special (exact name), or federal funds will be used: Health Services Cost Review Commission fund

D. If "no", identify the source(s) of funds necessary for implementation of these regulations: N/A

E. If these regulations have no economic impact under Part A, indicate reason briefly: N/A

F. If these regulations have minimal or no economic impact on small business under Part B, indicate the reason:

Title 10 DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Subtitle 37 HEALTH SERVICES COST REVIEW COMMISSION

Chapter 06 Submission of Hospital Discharge Data Set to the Commission

Authority: Health-General Article, §§19-207, 19-211, 19-212, 19-215, and 19-216, Annotated Code of Maryland

Notice of Proposed Action

The Health Services Cost Review Commission proposes to amend Regulation .01 under COMAR 10.37.06 Submission of Hospital Discharge Data Set to the Commission. This action was considered and approved for promulgation by the Commission at a previously announced open meeting held on October 9, 2013, notice of which was given pursuant to State Government Article, § 10-506(c), Annotated Code of Maryland. If adopted the proposed amendments will become effective on or about February 3, 2014.

Statement of Purpose

The purpose of this action is to require hospitals to submit monthly patient level inpatient discharge data in the manner and format prescribed by the Commission, and to enable the Commission to fully monitor population-based metrics and approved revenue under population-based payment models. Additionally, these proposed regulations are to be effective on January 1, 2014 since they represent an essential component in the development and implementation of new rate regulatory approaches and policies that encompass quality and clinical care improvement elements.

Comparison to Federal Standards

There is no corresponding federal standard to this proposed action.

Estimate of Economic Impact

See attachment.

Opportunity for Public Comment

Comments may be sent to Diana M. Kemp, Regulations Coordinator, Health Services Cost Review Commission, 4160 Patterson Avenue, Baltimore, Maryland 21215, or via fax to (410) 358-6217, or via email to diana.kemp@maryland.gov. The Health Services Cost Review Commission will consider comments on the proposed amendments until December 2, 2013. A hearing may be held at the discretion of the Commission.

.01 Collection and Submission of Data.

A. [Unless an exception or an extension has been granted under §C of this regulation.] Beginning on January 1, 2014, each hospital under the jurisdiction of the Health Services Cost Review Commission shall submit to the Commission:

(1) The data elements required by this chapter within [45] *15* days after the last day of the [quarter] *month* when the patient was discharged or died; and

(2) (text unchanged)

B. Submission Requirements.

(1) The data elements submitted under §A(1) o this regulation shall be made in the form as published in the Maryland Register and on the Commission's website [http://hscrc.state.md.us] *http://hscrc.maryland.gov*.

(2) (text unchanged)

C.-D. (text unchanged)

.01-1-.05 (text unchanged)

JOHN M. COLMERS
Chairman
Health Services Cost Review Commission

Estimate of Economic Impact

PART A

I. Summary of Economic Impact.

Hospitals will be required to submit inpatient data monthly, instead of quarterly. Monthly data submissions will improve HSCRC staff's ability to monitor population based metrics (including readmissions and MHACs) as well as approved revenue under population-based models on an ongoing basis.

II. Types of Economic Impact	Expenditure (E+/E-)	Revenue (R+/R-) Magnitude
A. On issuing agency:	E+	$135,000
B. On other State agencies:	NONE	
C. On local governments:	NONE	

	Cost(-) Benefit(+)	Magnitude
D. On regulated industries or trade groups:	(-)	Moderate
E. On other industries or trade groups:	NONE	
F. Direct and indirect effects on public:	NONE	

III. Assumptions. (Identified by Impact Letter and Number from Section II.)

A. These regulations increase the number of required submissions from hospitals. The magnitude reflects the increase in the cost to the data vendor to processes the additional submissions.

D. This regulatory change accelerates the time for submission of monthly patient-level inpatient data submissions, from 45 days to 15 days, improving the ability of HSCRC staff to monitor, produce annual rate orders, and provide feedback to hospitals in a timely manner. This change is highly desired by the payer and provider community as they develop and implement care intervention strategies. Although many hospitals already produce their case mix data on a monthly basis for internal purposes, there may be a moderate economic impact on the hospitals to produce the monthly case mix data for the HSCRC.

PART B

Economic Impact on Small Business

X The proposed action has minimal or no economic impact on small businesses

Or

___ The proposed action has a meaningful economic impact on small businesses. An analysis of this economic impact follows.

Impact on Individuals with Disabilities

X The proposed action has no impact on individuals with disabilities.

Or

___ The proposed action has an impact on individuals with disabilities as follows:

PART C

(For legislative use only, not for publication)

A. Fiscal Year in which regulations will become effective: 2014

B. Does the budget for fiscal year in which regulations become effective contain funds to implement the Regulations: N/A

X Yes or ____ No

C. If "yes", state whether general, special (exact name), or federal funds will be used: Health Services Cost Review Commission fund

D. If "no", identify the source(s) of funds necessary for implementation of these regulations: N/A

E. If these regulations have no economic impact under Part A, indicate reason briefly: N/A

F. If these regulations have minimal or no economic impact on small business under Part B, indicate the reason:

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

John M. Colmers
Chairman

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

George H. Bone, M.D.

Stephen F. Jencks, M.D., M.P.H.

Jack C. Keane

Bernadette C. Loftus, M.D.

Thomas R. Mullen

HEALTH SERVICES COST REVIEW COMMISSION
4160 Patterson Avenue, Baltimore, Maryland 21215
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hscrc.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: October 2, 2013

RE: Hearing and Meeting Schedule

Public Session:

November 6, 2013 1:00 p.m., 4160 Patterson Avenue, HSCRC Conference Room

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

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

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

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