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502nd MEETING OF THE HEALTH SERVICES COST REVIEW COMMISSION
November 6, 2013

EXECUTIVE SESSION
12:00 p.m.

1. **Waiver Update and Personnel Matters**

PUBLIC SESSION OF THE
HEALTH SERVICES COST REVIEW COMMISSION
1:00 p.m.

1. **Review of the Minutes from the Executive Session and Public Meeting on October 9, 2013 and the Executive Session on October 21, 2013**

2. **Executive Director's Report - Call for Papers: Implementation of Payment Systems**

3. **Docket Status – Cases Closed**

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

4. **Docket Status – Cases Open**

   2220N – University of Maryland Medical Center

5. **Final Recommendation on Changes to Financial Data Submission**

6. **Draft Recommendation on Update Factor effective January 1, 2014**

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

8. **Report on FY14 Uncompensated Care Policy and Draft Recommendation regarding Charity Care Adjustment**

9. **Legal Report**

10. **Hearing and Meeting Schedule**

HSCRC Implementation of Population-Based and Patient-Centered Payment Systems

Call for Papers

The Health Services Cost Review Commission (HSCRC) has an application under review with the Center for Medicare & Medicaid Services (CMS) for a new all-payer model and is now planning for implementation. The overarching change is to go from a system that bases control of cost on a per inpatient admission approach to a system that provides for control of cost on a per capita basis for both inpatient and outpatient hospital costs while requiring important care and health improvements. The implementation of the new Maryland system has the potential to serve as a national model, since managing per capita costs is based on the Three Part Aim of better health, better care, and reduced costs.

In order to achieve the goals of the new system, there will need to be substantial changes in policies and methodologies; the implementation of Maryland's modernized all-payer system will raise a number of technical and methodological issues. The HSCRC is seeking input from experts to guide its implementation activities through this call for papers and its ongoing public engagement strategy.

The HSCRC's public engagement strategy will convene an Advisory Council and Work Groups to provide input into the implementation work. The Advisory Council is charged with providing recommendations to the HSCRC on guiding principles for the implementation. Work Groups will be convened to provide recommendations on technical implementation issues. The purpose of the papers is to encourage individuals and organizations to actively participate in policy discussions in a well developed and fact-based manner. The goal is to have an informed dialogue in which the technical approaches and findings from different papers are discussed, refined and ultimately contribute to technical analyses that will support HSCRC policy decisions. The HSCRC will post all papers on-line and will develop a plan for encouraging dialogue and comment, which may be a part of the Work Group process, seminars or written comments.

All papers received in response to this call for papers will be shared with the HSCRC, Advisory Council members and Work Groups members. In addition, the HSCRC will post the papers on its implementation website.

Call for Technical Papers and Analyses

The HSCRC is requesting assistance from interested parties to prepare technical papers on several different topics. The purpose of the papers is to provide data analyses, policy analyses and background information to inform implementation decisions. The call for papers is for interested stakeholders, members of the research community and the general public who want to voluntarily contribute to the implementation planning. Interested

parties may respond to one or more of the topics below. The HSCRC will not provide compensation for the papers.

The authors should review Maryland's application for modernization of the all-payer model to ensure consistency among the papers and application. The application and information on the HSCRC's public engagement strategy can be found at hscrc.state.md.us. The papers should include a summary of the issue(s) and related problems; a detailed description of the proposed methodologies; the results and inputs of any analyses performed by the authors in easily accessible file format (i.e., Microsoft Excel or a similar format), as an appendix; and an assessment of the proposed method's implementation feasibility based on data that are currently available and an identification of any additional information that would be needed and how it could be acquired by the HSCRC.

Below is an initial set of topics for which the HSCRC is requesting technical papers. The HSCRC has identified three topics in the first group of papers, which should be addressed early in 2014. The timeline for the remaining papers in the second group is still in development. The Advisory Council and the Work Groups will have considerable input into the prioritization of issues and the schedules for the Work Groups. Given that these papers are likely to require significant analyses that will take time to complete, the topics are included in the call at this time.

The HSCRC recognizes that there may be some overlap among the issues identified. To the extent that stakeholders are responding to multiple issues, they may choose to address some of these issues collectively. Additionally, with any of the papers, submitters are invited to address some or all of the components of each paper. The HSCRC will update this call for papers as additional issues are identified.

First Group (papers due by January 10, 2014)

1. **Potentially Avoidable Volume**: A discussion and data analyses of different methodological approaches for measuring volume of services that could otherwise be avoided and techniques for incorporating measures in hospital payment methodology.

   The HSCRC has begun to consider strategies for distinguishing different types of volume change and how that could be factored into new payment methodologies. The HSCRC seeks input on what types of services could be considered potentially avoidable and what types of adjustments may be required. Specifically, input is sought on appropriate methodologies for identifying, measuring potentially avoidable volumes, such as ambulatory sensitive conditions, emergency department visits that could be served in other settings, avoidable inpatient admissions, and readmissions. HSCRC is also seeking input on how the measures can be incorporated into new hospital payment methodologies and the potential need for risk-adjustment.

2. **Methods for Monitoring Total Cost of Care**: The HSCRC is seeking papers to help identify methods for monitoring total cost of care and potential shifts from inpatient and outpatient settings to non-HSCRC regulated providers. The paper should address the feasibility of collecting and analyzing data and the potential sources of data and their timeliness.

3. **Service Area / Market Share**: An overview of methods and recommendations for defining hospital service areas and market share, and considerations for how service areas and market share should be factored into new payment models.

   The HSCRC seeks input on the techniques for defining service areas and calculating market share, including strategies for payment models that account for different types of volume changes and market share shifts. Input is also sought on: the best definitions of service areas and the sources of population data to support market share analyses; what services should be included in market share analyses and what are the best ways to account for changes in inpatient, outpatient and unregulated volume; the accuracy of zip code data and the challenges of using zip code data; and how to consider the utilization of Maryland residents and out-of-state residents.

Second Group (paper due dates to be determined)

4. **Attribution**: A discussion of the different techniques that could be used to attribute patients and/or populations and considerations for how attribution models could be included in new hospital payment models. The HSCRC seeks input on the different factors that should be considered in developing attribution models, such as geography, physicians or product line. This paper should build on an overview of techniques for defining service areas and measuring market shares, and consider how market share analyses and revenue allocation could be applied with attribution models.

5. **Variable Cost Factor**: An analysis of key variables and factors that should be considered in fixed and variable cost payment methodologies and the advantages and limitations of proposed approaches.

   The HSCRC seeks input on real examples of how fixed and variable costs are accounted for in payment systems, including how fixed and variable costs change over time, the impact of capacity on variable costs, and including changes in population or other influencing variables. Policy questions about how fixed and

variable costs should be applied in accounting for market share shifts and/or charge per case methodologies should also be addressed.

6. **Gain Sharing and Other Physician Alignment Programs**: A legal, policy and operational analysis of the opportunities of and barriers to sharing savings and other physician alignment efforts, in order to align physician payment with the new hospital payment models and incentives.

   The paper should consider whether gain sharing or other physician alignment initiatives should be implemented on an all-payer basis and the how this might be accomplished. The paper may consider whether there are opportunities to use the current Alternative Rate Setting Methods (ARM) structure to foster gain sharing or other physician alignment programs, and whether other policy or regulatory changes are needed.

7. **Efficiency and Value Measurement**: This paper should offer recommendations for how to measure efficiency and value in the new system. This measurement relates to the policy objectives of establishing payment levels that are reasonably related to the cost of providing services on an efficient basis and in accordance with the value concepts embodied in the new all-payer model proposed.

   The efficiency measures were focused on cost per case because the current system is measured based on cost per case. This paper should consider how efficiency should be measured in the new system, which may include cost per case, cost per episode, cost per condition, cost per capita, and other volume or population-based health measures. A cost per episode might also include post acute care costs that are incurred after a hospital stay. The paper could also address how a composite measure of performance can be created combining different domains of hospital performance such as quality, efficiency, and population health. For example, since the new system encourages improved health and improved care to reduce volume, the efficiency measures may take into account investments in better health and better care to reduce avoidable volumes and outcomes measures as evidence of better care. The paper could also address how to incorporate efficiency and value into the payment systems, and how to evaluate performance in the aggregate on a state-wide basis as well as hospital specific or for Medicare population.

8. **Payment Incentives for Quality-Based Reimbursement**: This paper should offer recommendations on how to measure and reward improved quality and better health through payment systems.

The HSCRC has currently two quality based payment programs, which are based on both process and outcome measures. The application to CMS has specific performance requirements for quality improvement and value-based payment that may have slight differences with the current HSCRC measurement for quality. In addition, new quality measures are being collected for outpatient services and there may be other measures that are not in the current programs. This paper should consider how to measure quality of hospital care, and how to incent improvements in health and quality. The paper should discuss the specific changes of measurement that might be warranted under a per capita model rather than a per case model. With respect to measurement, this paper should consider the domains to be measured, weightings, and methods of evaluation, such as performance versus self-improvement. Also, this paper should consider if and how quality measurement may evolve over time. With respect to payment policies, this paper should offer recommendation regarding level and distribution of payments, scaling methods, and how to build incentives into the payment system.

9. **Predictive Models for Uncompensated Care:** With the changes offered by the Affordable Care Act, uncompensated care is expected to decrease and the sources of uncompensated care are expected to change. Yet there will remain some individuals who do not enroll or are not eligible for insurance under the Health Benefit Exchange, particularly undocumented populations. In addition, some of the policies with high deductibles do not protect hospitals from incurring significant bad debts. The HSCRC uncompensated care policy has historically relied on a three year average analysis, which may need to be changed in the upcoming year given the magnitude of the changes that have occurred.

   The HSCRC seeks a paper on what factors to use in a predictive model that would be effective after July 1, 2014 , the sources of data for the model, and preliminary modeling analysis using those factors, including regression techniques and applications. The paper should also address how to measure charity care and bad debt policy and modeling approaches to include uncompensated care policy.

10. **Payment Models for Population Based Approaches:** Considerable efforts have been made to develop approaches for population based payment in Maryland. These models were developed to function in conjunction with the charge per case system. However, the new hospital all-payer model requires a fixed limitation in revenue growth. The HSCRC seeks papers and well developed examples using actual historical data regarding the approaches that would be appropriate for the new all-payer construct and the implications for measurement and management in the construct of a global statewide budget for revenue. The extent to which shared losses

and stop loss should be used, and how those losses should be allocated to other hospitals across the system should be addressed.

11. **Financing Major Capital Projects:** The HSCRC seeks papers that discuss how major hospital capital projects should be addressed under the new hospital payment models. The paper should develop and model potential options, including the potential for a capital facilities allowance, and how any capital dollars would fit within the context of the overall revenue constrained system.

Submission Requirements

Interested partied should let the HSCRC know if they plan to respond to this call for papers to help plan for volume of papers that may be received. A brief letter of intent should be emailed to hscrc.stakeholders@maryland.gov by November 8, 2013. The email should let the HSCRC know the organization or individual who will be responding, what topics will be addressed and any contact information. Please note that it is acceptable for a single paper to address multiple topics.

The first group of papers (topics 1 - 3) are due by January 10, 2014. The deadline for the remaining papers will be determined later and posted at hscrc.sttae.md.us. Final papers should be submitted to hscrc.stakeholders.gov. All papers should include an abstract of no more than 5 pages. All supporting data analyses and workbooks should be provided in an easily accessible file format (i.e., Microsoft Excel or a similar format).

All papers received in response to this call will be shared publically and posted to the HSCRC website. Authors should be aware that the papers and supporting documentation will not be treated as confidential analyses and the HSCRC may seek additional comment from others. The HSCRC may contact the authors for further clarifications or to reproduce their results using HSCRC data sets.

Call for Work Group Background Papers

In addition to this technical call for papers, the HSCRC will also provide an opportunity for interested parties to provide background papers for each of the Work Groups. The call for background papers will be made when the HSCRC finalizes its charge to each of the Work Groups and the specific issues for their consideration are outlined.

Questions related to this call for papers should be directed to hscrc.stakeholders@maryland.gov.

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

AS OF OCTOBER 25, 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
2220N	University of Maryland Medical Center	8/1/2013	11/6/2013	12/30/2013	TRAUMA	DNP	OPEN

NONE

PROCEEDINGS REQUIRING COMMISSION ACTION - NOT ON OPEN DOCKET

IN RE: THE APPLICATION OF	*	**BEFORE THE MARYLAND HEALTH**	
THE UNIVERSITY OF MARYLAND	*	**SERVICES COST REVIEW**	
MEDICAL CENTER	*	**COMMISSION**	
SHOCK TRAUMA CENTER	*	**DOCKET:**	**2013**
	*	**FOLIO:**	**2030**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2220N**

Staff Recommendation

November 6, 2013

I. INTRODUCTION

University of Maryland Medical Center (UMMC) filed an application on August 1, 2013 requesting approval of a new rate center for the Trauma Resuscitation Unit (TRU) that will enable outpatient billing for the Shock Trauma Center (STC). The requested rate center and rate, with an effective date of October 1, 2013, will be established in a revenue neutral manner by reclassifying revenue out of the STC Trauma (TRM) room and board rate center into the new TRU center. The separate rate for the TRU, necessitated by Medicare's "Two Midnight Rule," allows for the billing of patients not retained overnight under a separate outpatient rate structure.

II. BACKGROUND

STC's rate structure was created in 1980 as a part of the UMMC's full rate setting. Because of its unique mission as the flagship of the Maryland Institute for Emergency Medical Services System (MIEMSS), STC was mandated by law to have a separate and unique rate structure, which has remained unchanged from its initial rate setting. All patients brought to STC have been determined to require the intensive resources of STC at the trauma scene and currently receive an admission charge and daily routine room and board charge, along with charges for operating room, ancillary services and medical supplies and drugs provided.

It is imperative that all seriously ill and injured patients be delivered in a timely manner to the closest appropriate facility. There are 48 hospital emergency departments in Maryland. When patients need a higher level of care, MIEMMS has designated nine trauma centers and specialty referral centers for: burns; cardiac; spinal cord injuries; pediatric; eye; hand/upper extremity; hyperbaric; neurotrauma; perinatal; and stroke across the State. Maryland's Trauma and Emergency Medical Services (EMS) System ensures that the patient gets to the proper facility to receive the appropriate care through the use of statewide medical protocols by EMS providers. STC is the only Primary Adult Resource trauma center for Maryland, which requires 24/7 dedicated treatment facilities and in-house clinicians. The clinicians include attending trauma surgeons, orthopedic surgeons, neurosurgeons, anesthesiologists, and radiologists. The treatment facilities staffed 24/7 includes dedicated operating rooms, a Trauma Resuscitation Unit (TRU), Intensive Care Units (ICUs), as well as imaging, laboratory, and blood bank services.

All STC patients are transported via air or ambulance to the facility. MIEMSS protocols, applied by EMS personnel in the field, determine which patients will be brought to STC. Upon arrival at STC, all patients receive treatment as well as a detailed work-up in the TRU to determine the full extent of their injuries. After an extensive clinical evaluation in the TRU and treatment for

their injuries, about half of the patients are able to be released prior to an overnight stay.

Currently, the resources utilized in the detailed clinical evaluation and treatment provided in the TRU are bundled into the TRM room and board charges. Medicare's new requirements under the Two Midnight Rule, which requires outpatientbilling for patients not expected to stay in the hospital over two midnights, along with the evolution of similar protocols by other payers, necessitate changing STC's rate structure to establish an outpatient rate. This new rate center will allow STC to unbundle the TRU costs from the TRM room and board costs. This will allow cases not requiring an overnight stay to be billed as outpatient. Therefore, patients not staying overnight will no longer receive an Admission charge and a TRM room and board charge, but instead be charged the TRU rate.

III. TRU CENTER DEVELOPMENT

STC developed the requested TRU rate center and other applicable rates using costs contained in its FY 2012 annual filing. The establishment of the TRU rate center was facilitated by the fact that TRU and TRM are separate STC departments, so their costs are segregated.

The TRU rate was developed based on a one week time study, which STC determined to be representative of its population and experience. The steps taken to develop the rate center and resulting rates included:

1) Identify those patients who would be considered outpatients and who will no longer be charged an Admission charge or TRM room and board rate. This was determined to be any patients discharged directly from the TRU.
2) Calculate Clinical Care Time (CCT) (clinical care time is the combined total amount of time that each non-physician clinician spends treating the patient) for both inpatients and outpatients to develop Relative Value Units (RVUs) for the new TRU rate. The RVUs will be based on five acuity levels similar to the acuity levels used in the Emergency Departments at other acute care facilities.
3) Restate the volume statistics and break out revenue from the TRM revenue center based on the study period:
    - STC patient days and admissions were reduced to remove outpatients.
    - TRU RVUs were established based on the proportion of inpatients and outpatients for the five acuity levels, multiplied by their RVU assignments.
    - Revenue from the July 1, 2013 rate order was reclassified from the

TRM rate center to the new TRU rate center based on the restated FY 2012 annual filing.

- Using the restated revenue and volumes, new unit rates were calculated for TRU, TRM, and Admissions.

In addition, STC's Charge-per-Case target will need to be restated.

The new TRU rate requested is $115.11 per RVU, and the requested effective date is October 1, 2013.

IV. STAFF EVALUATION

Staff found that the approach used by UMMC to develop a separate TRU rate was reasonable. The approach used a historical annual filing, an estimated outpatient proportion based on a study period, and a time study. Staff found that the time study for the TRU-accumulated CCT rendered by non-physician providers, by category of service, included: triage, GI tasks, skeletal tasks, cardiac tasks, respiratory tasks, EKG tasks, and monitoring for both inpatients and outpatients. Ancillary type services listed were performed in the TRU by TRU personnel. Ancillary services provided by personnel assigned to ancillary departments were not included in the TRU costs. The non-physician providers included: nurses, technicians, and interns/fellows. The time study indicated that the average CCT for inpatients was 12.1 hours versus 7.4 hours for outpatients. The five charge levels were established to arrive at a reasonable bell curve:

TRU	Levels	CCT Hours
	Level 1	0 – 3
	Level 2	3 – 5
Level	3	5 – 10
Level	4	10 – 16
	Level 5	16 - 100

The top 20 primary discharge diagnoses were provided by the Hospital and are consistent with those that would be expected. The five most common primary discharge diagnoses for outpatients were: 1) Concussion w coma NOS; 2) Open Scalp wound; 3) Contusion of the Face, Scalp and neck except eyes; 4) Open Wound of Forehead; and 5) Concussion w/o LOC.

V. ST AFF RECOMMENDATION

The creation of the new TRU rate center willeliminate the charging of an Admission and room and board rate to patients who do not require inpatient care. In addition, implementation of the TRU rate more accurately assigns the cost of the resources utilized by each STC patient.

Therefore, the staff recommends:

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

Amend Regulation to Change Monthly Financial and Statistical Reporting

FINAL STAFF RECOMMENDATION

November 6, 2013

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

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. The 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, the 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.

It should be noted that it is likely that the hospitals that have traditionally been referred to as non-waiver hospitals will be included in the new Medicare test, thus requiring these facilities to submit data for the HSCRC's monitoring needs.

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, the 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 Commission in the expanded format by November 15, 2013. 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, the 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. The 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

The HSCRC has been seeking hospital input during the development process. HSCRC staff has provided content examples to hospitals for the new monthly and historical data reporting requirements.

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 the 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.
3) Any facility that believes it cannot meet the reporting deadlines should contact staff immediately, in writing. Staff will work with the hospitals to resolve the issues to ensure the statewide data requirements are met.

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

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

November 6, 2013

This document contains the preliminary staff recommendations for continuation of the existing update factor policies through June 30, 2014. These draft recommendations are for Commission consideration at the November 6, 2013 Public Commission Meeting. No action is required. Public comments should be sent to Steve Ports at the above address or by e-mail at Steve.Ports@Maryland.gov. For full consideration, comments must be received by November 20, 2013.

A. Introduction

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

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

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

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

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

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

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

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

Recommendation 5: Continue reallocation of the inpatient revenue for FY2014

Recommendation 6: No ROC Scaling for FY2014

B. New Framework for All Payer Model Design

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

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

C. Market Basket and Medicare IPPS and OPPS Rules

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

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

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

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

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

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

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

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

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

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

D. Findings and Recommendations

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

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

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

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

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

November 6, 2013

This draft recommendation was by the Maryland Health Care Commission & Health Services Cost Review Commission staff for consideration at the Commission's November 6, 2013 public meeting. No action is required. Public comments should be sent to Dianne Feeney at the above address or by e-mail at Dianne.Feeney@Maryland.gov. For full consideration, comments must be received by November 20, 2013.

CRISP State Designated Health Information Exchange

Funding Request

Overview

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

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

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

CRISP's Role and History of Funding

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

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

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

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

CRISP'S Role With HSCRC

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

Staff Recommendation

The MHCC and HSCRC recommend funding of up to $1.5 million annually through Maryland's unique all-payer hospital rate setting system to CRISP over the next five years (FY 2015 – FY 2019) to support the continued development and use of the State-Designated HIE. The continued funding is necessary to meet the anticipated uses of health information exchange as well as the needs of the HSCRC under the new All-Payer Model Design proposed to the Centers for Medicare and Medicare Innovation (CMMI), and for quality measurement and improvement such as monitoring and reducing readmissions across the State.

The funding can also be used to leverage federal fiscal participation (90/10 match requirement) under the Health Information Technology for Economic and Clinical Health (HITECH) Act. HITECH enables states to be approved for funding by CMS under the Medicaid EHR Incentive Program and receive a 90 percent federal financial participation match for expanding HIE through 2021.

HITECH funding is based on a state's overall financial plan that leverages multiple funding sources to develop and maintain HIEs between hospitals, health systems and individual practices. All combined, based on the Medicaid/ DHMH submission of the required Implementation Advanced Planning Document (IAPD) application, CMS approved approximately $6.2M of

matching funds under HITECH for HIE development in fiscal years 2013 and 2014 using funding through DHMH. While this funding is not available in FY 2015, other matching funds are available as outlined above.

The annual funding to CRISP, including both the amount received through rates and any IAPD matching funds, will be determined by an annual MHCC and HSCRC combined staff evaluation. Receiving the full amount each year will be based upon CRISP achieving performance goals established annually by the CRISP Board of Directors, and performance on select activities requested by MHCC and HSCRC. HSCRC and MHCC will continue to review the sustainability of CRISP under multiple sources of funds from HSCRC fees, grants, user fees, and other revenue sources.

Appendix

OVERVIEW OF CRISP--HISTORY, GOVERNANCE, AND OPERATIONS

History and Purpose

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

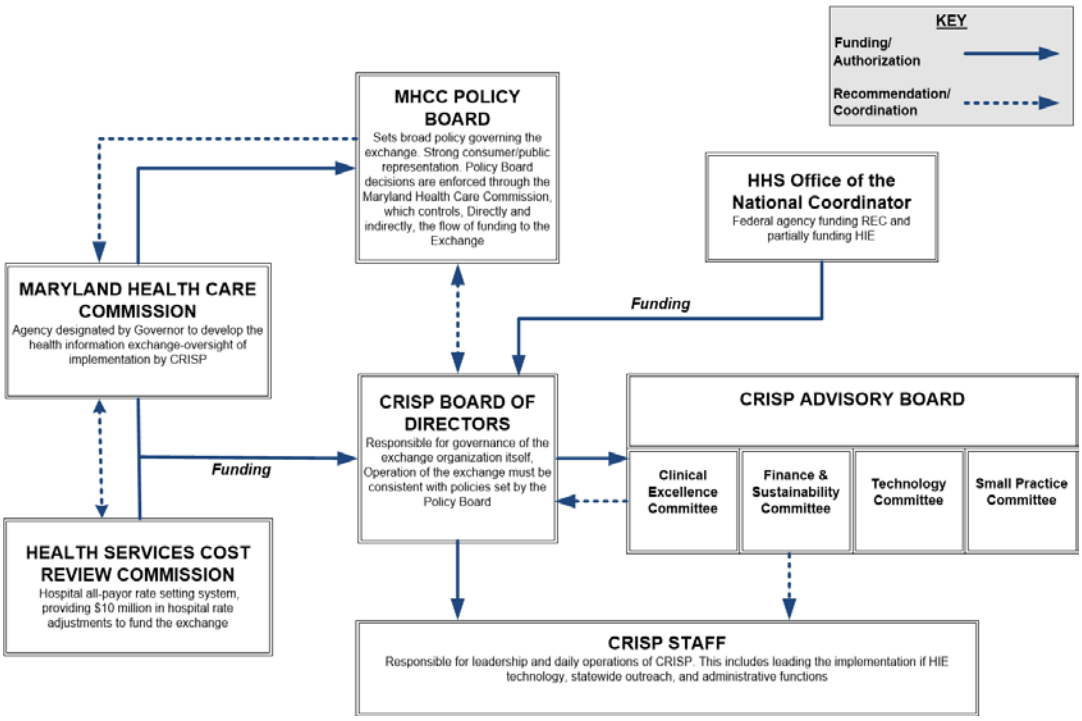
In April 2009, MHCC issued a competitive Request for Application (RFA) for designation as the State-Designated HIE. Several months later, after a thorough evaluation by a national review team, MHCC and HSCRC designated CRISP as the State-Designated HIE. The MHCC and CRISP entered into a three-year Memorandum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

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

State Designated HIE – CRISP Governance Structure

CRISP is an independent non-stock Maryland membership corporation, qualified as tax-exempt under Section 501(c)(3) of the Internal Revenue Code. Founding members of CRISP include: the Johns Hopkins Health System; MedStar Health; University of Maryland Medical System; Erickson Retirement Communities; and Erickson Foundation. The CRISP Board of Directors consists of nine appointees of the original members, two payer representatives, two Secretary of DHMH appointees, two community representatives, and two small physician practice

representatives. In addition, MHCC and HSCRC staff, along with more than two dozen major stakeholders across the State, participate on various CRISP advisory boards.



Key Accomplishments

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

The State-Designated HIE is envisioned to eventually support a basic level of interoperability to communicate authenticated EHR systems data among providers. The State-Designated HIE will also enable communities with service area HIEs to connect to other communities around the State and, in the future, with providers in other states. During its initial three-year State designation, CRISP has shown both a commitment to the objectives set forth in State law for the development of HIE and the technical ability to achieve those objectives.

Milestones

The State-Designated HIE has made considerable progress in achieving critical milestones. These milestones have enabled CRISP to provide value to providers and patients statewide. The

milestones listed below are considered by MHCC and HSCRC staff as noteworthy achievements over the last several years.

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

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

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

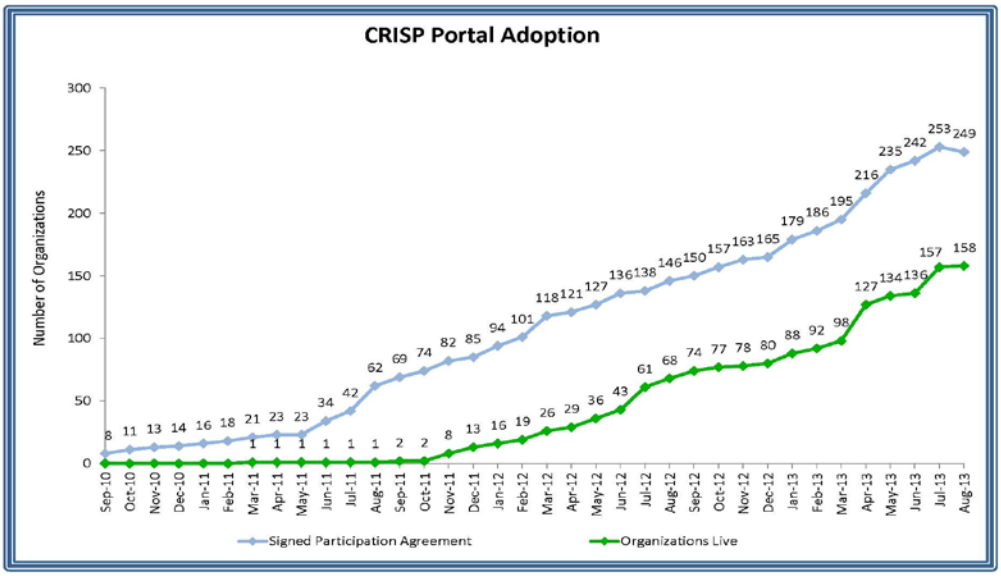
Annual Performance

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

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

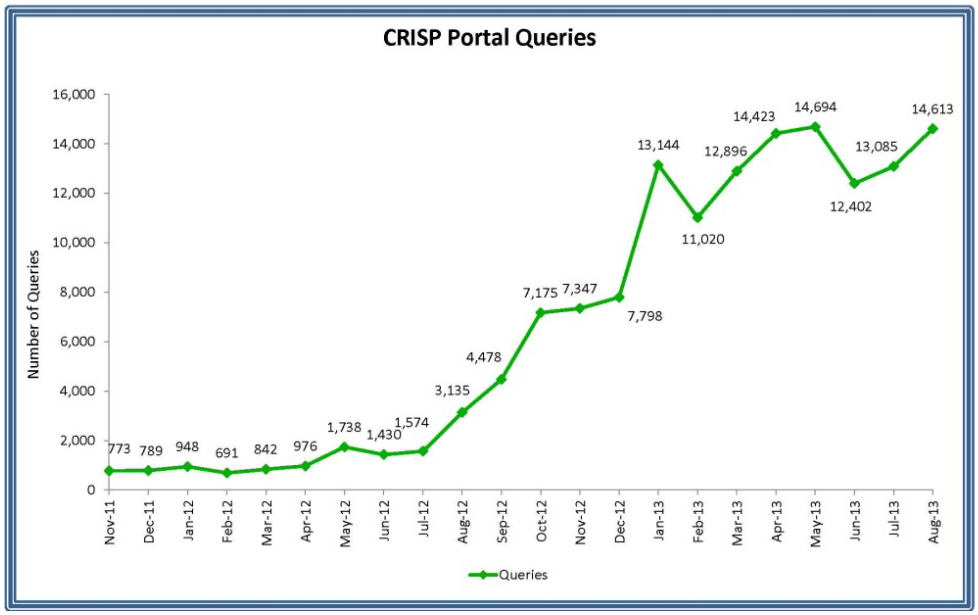
Query Services – Adoption

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



Queries Services – Volume

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

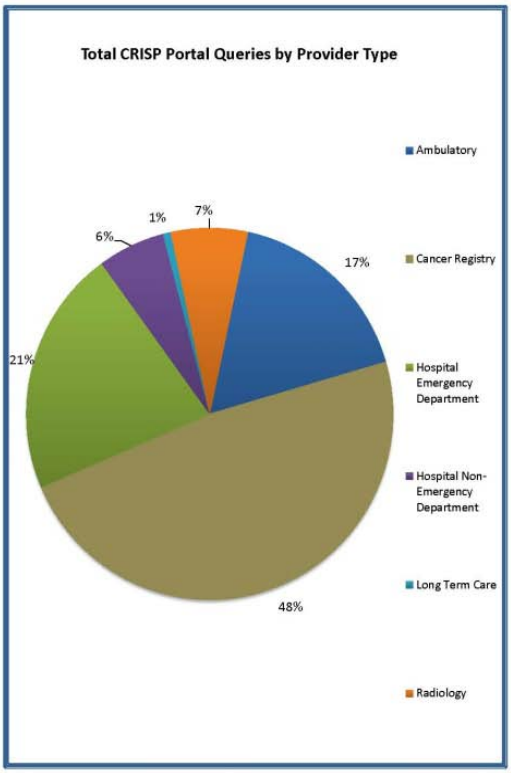


Query Services – Provider Distribution

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

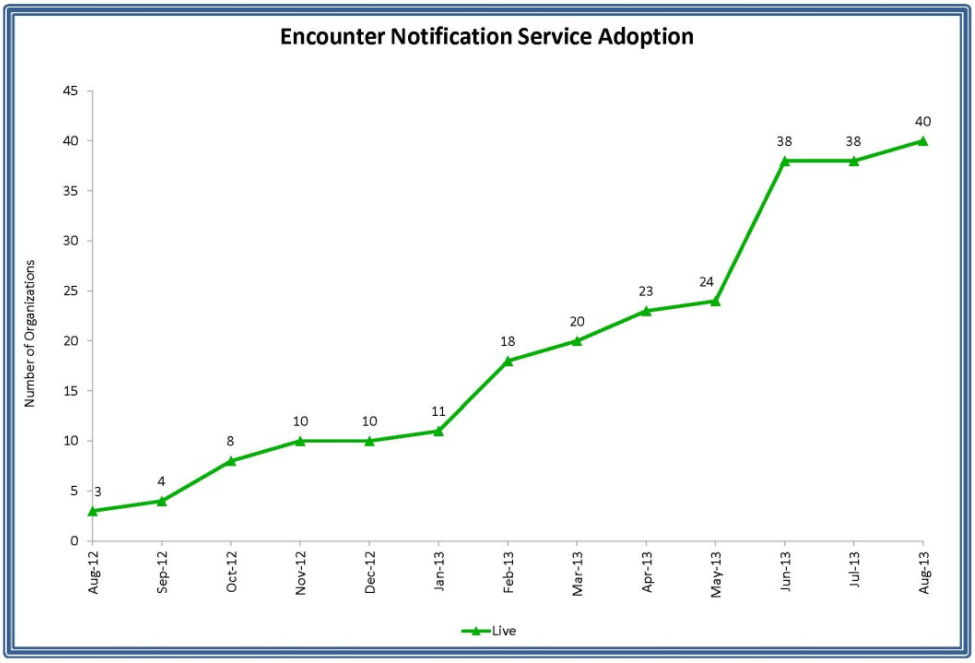
CRISP Portal Queries by Provider Type

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



Encounter Notification Services – Participating Organizations

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



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October 29, 2013

To: HSCRC Commissioners

From: Claudine Williams, Associate Director, Policy Analysis

Re: Status of CRISP Unique ID to HSCRC data Link

Background

The HSCRC collaborated with the Chesapeake Regional Information System for Our Patients (CRISP), which is the State's designated health information exchange (HIE) organization, to create a unique patient identifier (EID) that would enable tracking patients across the hospitals in the State.

Current Status

HSCRC and CRISP have been working together with hospitals to refine the unique patient identifier. Appendix 1 describes in more detail the patient linking methodology that CRISP uses. During the September 5, 2013 Commission meeting, HSCRC staff reported that CRISP was able to assign EIDs to 98.6% of inpatient records and 89.3% of outpatient records for CY 2012 (see Table 1). As of October 2013, the percent of inpatient records assigned with an EID increased to 99.9%, and the percent of outpatient records assigned with an EID also increased to 95.1%.

Table 1: State-wide Status of EID Assignment

As of July 2013						As of October 2013					
Inpatient - % of Visits		Outpatient % of Visits		All Visits % of Visits		Inpatient % of Visits		Outpatient % of Visits		All Visits % of Visits	
With EIDs	No EID	With EIDs	No EID	With EIDs	No EID	With EIDs	No EID	With EIDs	No EID	With EIDs	No EID
98.6%	1.4%	89.3%	10.7%	90.3%	9.7%	99.9%	0.1%	95.1%	4.9%	95.6%	4.4%

Although the state-wide percentage of the records with EIDs was in the high 90's in July, additional work needed to be done to make sure individual hospitals had relatively high percentages of records with EIDs assigned. Table 2 compares the percent of records assigned an EID, by hospital, in July and October. There is only 1 hospital with a matching rate of less than

99% for inpatient records in October and the issue is being addressed with the hospital.

Table 2: Status of EID Assignment, By Hospital

		As of July 2013						As of October 2013					
		Inpatient - % of Visits		Outpatient % of Visits		All Visits % of Visits		Inpatient % of Visits		Outpatient % of Visits		All Visits % of Visits	
Hosp ID	Hospital	% W/EID	% W/O EID	% W/EID	% W/O EID	% W/EID	% W/O EID	% W/EID	% W/O EID	% W/EID	% W/O EID	% W/EID	% W/O EID
TOTAL	Statewide	98.6%	1.4%	89.3%	10.7%	90.3%	9.7%	99.9%	0.1%	95.1%	4.9%	95.6%	4.4%
210001	MMC	98.4%	1.6%	96.1%	3.9%	96.4%	3.6%	99.6%	0.4%	97.2%	2.8%	97.6%	2.4%
210002	UMMS_UMMC	96.2%	3.8%	98.6%	1.4%	98.3%	1.7%	99.8%	0.2%	99.8%	0.2%	99.8%	0.2%
210003	PGHC	100.0%	0.0%	100.0%	0.0%	100.0%	0.0%	100.0%	0.0%	100.0%	0.0%	100.0%	0.0%
210004	HCH	98.2%	1.8%	95.5%	4.5%	96.1%	3.9%	100.0%	0.0%	100.0%	0.0%	100.0%	0.0%
210005	FMH	99.5%	0.5%	99.5%	0.5%	99.5%	0.5%	100.0%	0.0%	100.0%	0.0%	100.0%	0.0%
210006	HARM	100.0%	0.0%	100.0%	0.0%	100.0%	0.0%	100.0%	0.0%	100.0%	0.0%	100.0%	0.0%
210007	SJMC	99.9%	0.1%	99.8%	0.2%	99.8%	0.2%	100.0%	0.0%	100.0%	0.0%	100.0%	0.0%
210008	MHS	100.0%	0.0%	100.0%	0.0%	100.0%	0.0%	100.0%	0.0%	100.0%	0.0%	100.0%	0.0%
210009	JHH	100.0%	0.0%	75.1%	24.9%	76.6%	23.4%	100.0%	0.0%	75.6%	24.4%	77.1%	22.9%
210010	UMMS_DRCHSTR	99.8%	0.2%	99.7%	0.3%	99.7%	0.3%	99.9%	0.1%	99.7%	0.3%	99.7%	0.3%
210011	SAH	100.0%	0.0%	100.0%	0.0%	100.0%	0.0%	100.0%	0.0%	100.0%	0.0%	100.0%	0.0%
210012	LBH_SHB	99.5%	0.5%	98.8%	1.2%	98.9%	1.1%	100.0%	0.0%	99.6%	0.4%	99.7%	0.3%
210013	BSB	100.0%	0.0%	100.0%	0.0%	100.0%	0.0%	100.0%	0.0%	100.0%	0.0%	100.0%	0.0%
210015	MEDSTAR_FSH	100.0%	0.0%	100.0%	0.0%	100.0%	0.0%	100.0%	0.0%	100.0%	0.0%	100.0%	0.0%
210016	ADVWAH	98.6%	1.4%	97.9%	2.1%	98.1%	1.9%	100.0%	0.0%	100.0%	0.0%	100.0%	0.0%
210017	GCMH	100.0%	0.0%	100.0%	0.0%	100.0%	0.0%	100.0%	0.0%	100.0%	0.0%	100.0%	0.0%
210018	MGH	100.0%	0.0%	100.0%	0.0%	100.0%	0.0%	100.0%	0.0%	100.0%	0.0%	100.0%	0.0%
210019	PRMC	100.0%	0.0%	99.9%	0.1%	99.9%	0.1%	99.9%	0.1%	99.9%	0.1%	99.9%	0.1%
210022	SUBURBAN	99.3%	0.7%	99.3%	0.7%	99.3%	0.7%	99.3%	0.7%	99.3%	0.7%	99.3%	0.7%
210023	AAMC	100.0%	0.0%	100.0%	0.0%	100.0%	0.0%	100.0%	0.0%	100.0%	0.0%	100.0%	0.0%
210024	MEDSTAR_UMH	100.0%	0.0%	100.0%	0.0%	100.0%	0.0%	100.0%	0.0%	100.0%	0.0%	100.0%	0.0%
210027	WMHS	99.8%	0.2%	99.9%	0.1%	99.9%	0.1%	99.9%	0.1%	99.9%	0.1%	99.9%	0.1%
210028	STMH	100.0%	0.0%	99.8%	0.2%	99.8%	0.2%	100.0%	0.0%	99.9%	0.1%	99.9%	0.1%
210029	JHH_BVIEW	99.6%	0.4%	77.5%	22.5%	78.7%	21.3%	99.6%	0.4%	77.7%	22.3%	78.9%	21.1%
210030	UMMS_CHSTR	99.8%	0.2%	99.5%	0.5%	99.5%	0.5%	99.8%	0.2%	99.7%	0.3%	99.7%	0.3%
210032	UHCC	97.4%	2.6%	99.7%	0.3%	99.5%	0.5%	98.1%	1.9%	100.0%	0.0%	99.9%	0.1%
210033	CHC	100.0%	0.0%	100.0%	0.0%	100.0%	0.0%	100.0%	0.0%	100.0%	0.0%	100.0%	0.0%
210034	MEDSTAR_HHC	95.6%	4.4%	97.5%	2.5%	97.3%	2.7%	100.0%	0.0%	100.0%	0.0%	100.0%	0.0%
210035	CMC	100.0%	0.0%	100.0%	0.0%	100.0%	0.0%	100.0%	0.0%	100.0%	0.0%	100.0%	0.0%
210037	UMMS_EASTON	99.7%	0.3%	99.5%	0.5%	99.5%	0.5%	99.7%	0.3%	99.6%	0.4%	99.6%	0.4%
210038	UMMS_MGH	99.1%	0.9%	99.2%	0.8%	99.2%	0.8%	99.8%	0.2%	99.8%	0.2%	99.8%	0.2%
210039	CVMH	100.0%	0.0%	100.0%	0.0%	100.0%	0.0%	100.0%	0.0%	100.0%	0.0%	100.0%	0.0%
210040	LBH_NWH	100.0%	0.0%	100.0%	0.0%	100.0%	0.0%	100.0%	0.0%	100.0%	0.0%	100.0%	0.0%

Table 2: Status of EID Assignment, By Hospital

		As of July 2013						As of October 2013					
		Inpatient - % of Visits		Outpatient % of Visits		All Visits % of Visits		Inpatient % of Visits		Outpatient % of Visits		All Visits % of Visits	
Hosp ID	Hospital	% W/EID	% W/O EID	% W/EID	% W/O EID	% W/EID	% W/O EID	% W/EID	% W/O EID	% W/EID	% W/O EID	% W/EID	% W/O EID
210043	UMMS_BWMC	99.7%	0.3%	99.7%	0.3%	99.7%	0.3%	99.9%	0.1%	100.0%	0.0%	100.0%	0.0%
210044	GBMC	99.5%	0.5%	99.3%	0.7%	99.4%	0.6%	100.0%	0.0%	100.0%	0.0%	100.0%	0.0%
210045	MCMH	100.0%	0.0%	100.0%	0.0%	100.0%	0.0%	100.0%	0.0%	100.0%	0.0%	100.0%	0.0%
210048	HCGH	100.0%	0.0%	100.0%	0.0%	100.0%	0.0%	100.0%	0.0%	100.0%	0.0%	100.0%	0.0%
210049	UCMC	100.0%	0.0%	100.0%	0.0%	100.0%	0.0%	100.0%	0.0%	100.0%	0.0%	100.0%	0.0%
210051	DCH	100.0%	0.0%	100.0%	0.0%	100.0%	0.0%	100.0%	0.0%	100.0%	0.0%	100.0%	0.0%
210054	SMH (old)	99.3%	0.7%	99.6%	0.4%	99.6%	0.4%	99.5%	0.5%	99.8%	0.2%	99.7%	0.3%
210055	LRH	100.0%	0.0%	100.0%	0.0%	100.0%	0.0%	100.0%	0.0%	100.0%	0.0%	100.0%	0.0%
210056	MEDSTAR_GSH	100.0%	0.0%	98.8%	1.2%	99.0%	1.0%	100.0%	0.0%	98.8%	1.2%	99.0%	1.0%
210057	ADVSGAH	99.2%	0.8%	0.1%	99.9%	20.5%	79.5%	100.0%	0.0%	100.0%	0.0%	100.0%	0.0%
210058	UMMS_KERNAN	94.9%	5.1%	75.7%	24.3%	77.0%	23.0%	99.9%	0.1%	76.8%	23.2%	78.4%	21.6%
210060	FWMC	100.0%	0.0%	99.8%	0.2%	99.8%	0.2%	100.0%	0.0%	99.9%	0.1%	99.9%	0.1%
210061	AGH	99.1%	0.9%	95.3%	4.7%	95.4%	4.6%	99.1%	0.9%	95.3%	4.7%	95.4%	4.6%
210062	SMH (new)	99.0%	1.0%	99.7%	0.3%	99.6%	0.4%	99.2%	0.8%	99.8%	0.2%	99.7%	0.3%
210087	GERMANTOWN ER			0.0%	100.0%	0.0%	100.0%			100.0%	0.0%	100.0%	0.0%
210088	QUEEN ANNE ER			0.0%	100.0%	0.0%	100.0%			99.4%	0.6%	99.4%	0.6%
210333	BOWIE			0.0%	100.0%	0.0%	100.0%			100.0%	0.0%	100.0%	0.0%
210904	JHH ONCOLOGY	0.0%	100.0%	0.0%	100.0%	0.0%	100.0%	100.0%	0.0%	89.6%	10.4%	90.1%	9.86%
212005	LEVINDALE			0.0%	100.0%	0.0%	100.0%			45.5%	54.5%	45.5%	54.6%
212007	UM SPEC			0.0%	100.0%	0.0%	100.0%			99.9%	0.1%	99.9%	0.1%
213028	CHES REHAB			0.0%	100.0%	0.0%	100.0%			0.0%	100.0%	0.0%	100.0%
218992	UMMS_UMMC			0.0%	100.0%	0.0%	100.0%			99.9%	0.1%	99.9%	0.1%
218994	UMMS_UMMC			0.0%	100.0%	0.0%	100.0%			100.0%	0.0%	100.0%	0.0%

Next Steps

Hospitals will be submitting the required demographic information used in the creation of EIDs to HSCRC/ CRISP by the end of October 2013 for visits where CRISP could not assign an EID for CY 2012. Staff anticipates having 100% matching rates for this time period once the additional information is processed. In the meantime, staff has begun using the EID data for calculating state-wide inter-and intra-readmission rates, and the ratio of inter versus intra hospital readmissions is similar to results from other studies. Next, staff will compare, by hospital, Medicare readmission rates against readmission rates calculated from MedPar data for additional validation of the EIDs.

As soon as CY 2013 is complete, CRISP and HSCRC will work with hospitals to make sure that all visits in CY 2013 are assigned EIDs as well.

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Appendix 1: CRISP Patient Identity Management Overview and Current CRISP ID to HSCRC Data Link Rate Status

Overview

In 2011, HSCRC began work with CRISP to leverage CRISP's HIE infrastructure to allow Maryland to develop reliable statewide approach to linking medical record numbers across hospitals to asses inter-hospital readmission activity. The approach relies on CRISP's master patient index technology that employs a probabilistic matching algorithm. Specifically, CRISP uses IBM's MDM Standard product (previous called "Initiate") that allows for Maryland-specific configuration to produce the most accurate linking, limiting false positive correlations to near zero while avoiding a proportional increase in false positives.

Link Rate Progress

Linking the CRISP ID to the HSCRC Tape data is a priority. Steady progress has been made to improve the linking of the data.

- In April, 2013, CRISP was able to link **99.5%** of CY 12 inpatient records to a CRISP ID. The April match was done for the 46 acute care hospitals for inpatient visits and did not include other facilities which submit inpatient visits, such as Hopkins Oncology.

- In July 2013, CRISP include all hospitals submitting inpatient data to CRISP and the inpatient EID lookup rate fell to **98.6%** for CY12 inpatient visits. CRISP also began a look-up process for CRISP IDs for outpatient visits. The initial link rate was **89.3%** of CY12 outpatient visits. While CRISP receives all inpatient and ED feeds from hospital, not all hospitals were sending all outpatient feeds through CRISP. Additionally, several hospitals had implemented filters for certain patient types.

- The **current status** of EID lookup for CY12 visits (as October 1st, 2013):
  - Inpatient: **99.9%** of all CY 2012 Inpatient hospital records have a CRISP ID.
    - Only 1 hospital is below 99%, with matching rates of 98.1%.
    - The cause has been identified and improvements are being made through the data improvement initiative.

  - Outpatient: **95.1%** of all CY 2012 Outpatient records have a CRISP ID.

- The outpatient data should improve significantly as more hospitals send retroactive patient demographics information and begin transmitting non-ER outpatient data to CRISP in the coming months.

- The overall EID lookup rate for HSCRC CY12 Inpatient and Outpatient visits is **95.6%.**

Patient Linking Methodology

CRISP to HSCRC Data ID Assignment

CRISP receives real-time hospital encounter messages (called "ADTs") which carry facility, medical record number, visit IDs, and other demographic information about patient visit. ADT messages flow through CRISP in real-time and are assigned a unique identifier relying on the probabilistic matching algorithm. Because the hospital reported HSCRC data includes overlapping data elements (facility IDs, medical record numbers, visit IDs), the unique CRISP ID can be appended to the tape data by matching the overlapping elements present in both data sets.

Identification Process

When a message is sent from a hospital for a given patient, the MPI first evaluates the demographic data within the message. The MPI will first attempt to match the patient with existing patient identities. If a match is successful (i.e. exceeds a threshold score), the identifier for the existing identity will be assigned to the message and the MRNs will be linked together. If no match is successful, then the patient will be considered a new person and a new identifier will be generated and assigned.

Probabilistic Matching

MDM Standard uses a sophisticated probabilistic matching algorithm to determine if the message is for an existing patient or if the message is for a new patient. MDM Standard's algorithm creates a match score to represent the degree of certainty for an exact match based of a long list of patient identifying data fields. Full points are award for exact matches but partial points are also given for common but minor data discrepancies such as the use of nicknames, middle initials, and some transposed dates and numbers. The final score is a reflection of the match certainty between an existing identity and the identity for the record to be matched. Specifically, the tool incorporates various approaches to processing information that inherently had data quality challenges.

- Edit distance calculations: the number of changes needed for two values to be equivalent. The fewer the number of changes, the more likely the records are a match.
- Enhanced Soundex: names with similar phonetic sounds receive a higher score.
- False positive filter (FPF): applies deterministic logic to specific false positive matches, and uses the result to apply a penalty score.
- Frequency indexing: common names receive lower scores, uncommon names receive higher scores.
- Historical values in matching: the use of previous addresses or names (maiden names) as part of the matching technology that allows for a stronger link between records and consequently a larger number of matches.
- Nickname tables: tables that equate formal and informal names.

Custom Weights

Initiate's matching algorithm allows custom weights to be assigned to a wide range of uniquely identifying data elements, such as names, addresses, phone numbers, medical record numbers (MRN), and Social Security number (SSN). CRISP assigns different weights for different data elements depending on the element's match significance. For example, more weight is given for an exact SSN match and less for a gender match.

Matching Thresholds

Once the final match score is obtained, the individual will be evaluated using a dual-threshold approach. Identities with scores below the lower threshold will automatically be rejected as a match. Match search will continue to the next existing identity and a new identity will be created if there are no more identities to match with. Identities with scores above the upper threshold will automatically be considered as a match and linked with the existing identity. For scores between the two thresholds, a new identity will be created while the case is placed in a manual review queue where a person can make post-match corrections if necessary.

Balancing False Positives and False Negatives

When deploying an MPI solution, it is important to determine if an aggressive or conservative linking strategy will be pursued. Aggressive in this context, refers to erring on the side of linking records, as opposed to working to avoid false positives as an imperative (conservative). It is possible to tune an algorithm to minimize the number of false positives and false negatives; however, there is an important balance that will need to be addressed in regards to performance of the system and the amount of human intervention that will need to take place. Depending on the type of data that is being rendered, the tolerance for incorrect or missing matches will determine how finely tuned the algorithm will need to be in order to address the issue of false positives and false negatives. For instance, when dealing with healthcare data, it is imperative that records are linked appropriately with a very low rate of false positives and low rate of false negatives.

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

Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215
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November 6, 2013

This recommendation is a draft for Commission consideration at the Commission's November 6, 2013 public meeting. No action is required. Public comments should be sent to Nduka Udom at the above address or by e-mail at Nduka.Udom@Maryland.gov. For full consideration, comments must be received by November 20, 2013.

Introduction

The purpose of this report is to detail the results of applying the Uncompensated Care Policy for Fiscal Year 2013 and to recommend that the Commission modify the formula applied to arrive at hospital specific amounts of withdrawals from the Uncompensated Care Pool, based on inconsistencies in reporting of charity care expense across hospitals.
The HSCRC's provision for uncompensated care in hospital rates is one of the unique features of rate regulation in Maryland. Uncompensated care (UCC) includes bad debt and charity care. By recognizing reasonable levels of bad debt and charity care in hospital rates, the system enhances access to hospital care for those patients who cannot pay for care. The uncompensated care methodology has undergone substantial changes over the years since it was initially established in 1983. The most recent version of the policy was adopted by the Commission on September 1, 2010.

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

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

The Uncompensated Care Model

The uncompensated care regression estimates the relationship between a set of explanatory variables and the rate of uncompensated care observed at each hospital as a percentage of gross patient revenue. Under the current policy, the following variables are included as explanatory variables:

- The proportion of a hospital's total charges from inpatient non-Medicare admissions through the emergency room;
- The proportion of a hospital's total charges from inpatient Medicaid, self-pay, and charity cases;
- The proportion of a hospital's total charges from outpatient Medicaid, self-pay, and charity visits to the emergency room; and

- The proportion of a hospital's total charges from outpatient charges.

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

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

UCC Result for FY 2014 Rate Year

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

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

The Charity Care Adjustment

The Charity Care Adjustment was adopted by the Commission on October 14, 2009 to recognize the charity care provided by Maryland hospitals and reported to the Commission each year. This policy grew out of provisions included in 2009 legislation (Chapters 310 and 311) which required the Commission to study and make recommendations on incentives for hospitals to provide free and reduced-cost care to patients without the means to pay their hospital bills. The legislation also established a minimum statewide hospital financial assistance threshold (of 150 percent of FPL, later increased by the Commission through regulation to 200 percent of FPL), and other requirements relating to hospital debt collection.

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

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

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

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

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

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

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

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

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

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

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

Affordable Care Act Impact on UCC: Future Considerations

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

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

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

Based on the wide hospital-level variation in the percentage of charity care reported from 2011 to 2012, staff does not have confidence that the current Charity Care Adjustment policy accurately distinguishes charity care from bad debts. Staff also is not confident that charity care is accurately and consistently reported by hospitals, which may well relate to the implementation of presumptive charity care software by some hospitals and insufficient identification of patients meeting charity guidelines by others. Finally, the current UCC Policy, absent the Charity Care Adjustment, fully adjusts rates for all uncompensated care historically provided by hospitals. Therefore, staff recommends that the Commission suspend the Charity Care Adjustment for FY 2014 until an alternative Charity Care Adjustment methodology is developed and approved. A final recommendation will be brought to the Commission at the December 2013 meeting.

APPENDIX I

Fiscal Year 2012 Data Used in Regression for FY 2014

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

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

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APPENDIX II

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

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

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

Title 10 DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Subtitle 37 HEALTH SERVICES COST REVIEW COMMISSION

Chapter 01 Uniform Accounting and Reporting System for Hospitals and Related Institutions

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

NOTICE OF PROPOSED ACTION

The Health Services Cost Review Commission proposes to amend Regulations **.02** under **COMAR 10.37.01 Uniform Accounting and Reporting System for Hospitals and Related Institutions**. This action was considered and approved for promulgation by the Commission at a previously announced open meeting held on November 6, 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 March 3, 2014.

Statement of Purpose

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

Comparison of Federal Standards

There is no corresponding federal standard to this proposed action.

Estimate of Economic Impact

The proposed action has no economic impact.

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 (410) 764-2576, or fax to (410) 358-6217, or email to diana.kemp@maryland.gov. The Health Services Cost Review Commission will consider comments on the proposed amendments until January 2, 2014. A hearing may be held at the discretion of the Commission.

.02 Accounting System; Hospitals.

A. The Accounting System.

(1) (text unchanged)

(2) The "Accounting and Reporting System for Hospitals", also known as the Accounting and Budget Manual for Fiscal and Operating Management (August, 1987), is incorporated by reference, including the following supplements:

(a)-(s) (text unchanged)

(t) Supplement 20 (May 16, 2011); [and]

(u) Supplement 21 (July 9, 2012)[.]*; and*

(v) Supplement 22 (March 3, 2014).

(3) – (5) (text unchanged)

B. – D. (text unchanged)

JOHN M. COLMERS

Chairman
Health Services Cost Review Commission

Title 10 DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Subtitle 37 HEALTH SERVICES COST REVIEW COMMISSION

Chapter 01 Uniform Accounting and Reporting System for Hospitals and Related Institutions

Authority: Health-General Article, §§19-207, 19-211, 19-212, 19-215—19-217, 19-218, 19-220, 19-224, and 19-303, Annotated Code of Maryland

Notice of Emergency Action

The Health Services Cost Review Commission has granted emergency status to amend Regulation **.03** of **COMAR 10.37.01** Uniform Accounting and Reporting System for Hospitals and Related Institutions.

Emergency Status Begins: January 1, 2014

Emergency Status Expires: April 1, 2014

Comparison of Federal Standards

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

Estimate of Economic Impact

See attachment.

.03 Reporting Requirements; Hospitals

A.-C. (text unchanged)

D. Monthly Reports of Achieved Volumes [.] *and Revenue*.

(1) The following monthly volume *and revenue* reports to be submitted by each [Section 556] hospital *under the jurisdiction of the Commission*, with the exception of those hospitals that are a part of the Department of Health and Mental Hygiene:

(a) Statistical Data *and Revenue* Summary – Daily Hospital Services [(MS)];

(b) Statistical Data *and Revenue* Summary – Ancillary Services [(PSA, SB);]**.**

[(d) Gross Patient Revenues – (RSA, RSB, RSC);.]

(2) [Schedules MS, NS, PSA, PSB and RSA, RSB, and RSC] *The Monthly Reports of Achieved Volumes and Revenues* shall be completed on the basis of actual data in the [form] *format* prescribed by the Commission [contained in the "Accounting and Reporting System for Hospitals"].

(3) [Schedules MS, NS, PSA, PSB and RSA, RSB, and RSC] *The Monthly Reports of Achieved Volumes and Revenues* shall be submitted within 30 days after the end of each month of the calendar year in the format prescribed by the Commission.

*(4) The Monthly Reports of Achieved Volumes and Revenues submitted under §D of this regulation shall be made in the format as published in the Maryland Register and on the Commission's website [http://www.hscrc.maryland.gov]***.**

[E. Monthly Report of Rate Compliance.

(1) The following monthly report of rate compliance is required to be submitted by each Section 556 hospital, with the exception of those hospitals that are a part of the Department of Health and Mental Hygiene: Statistical Data Summary – Rate Compliance (CSA, CSB).

(2) Schedules CSA, CSB shall be completed on the basis of actual data in the form prescribed by the Commission contained n the "Accounting and Reporting System for Hospitals".

(3) Schedules CSA, CSB shall be submitted within 30 days after the end of each month of the calendar year in the format prescribed by the Commission.]

[F. Repealed.]

[G]*E.* Annual Report of Revenue and Volume Comparison.

(1)-(3) (text unchanged)

[H]*F.* Annual Reports of Revenues, Expenses and Volumes.

(1)-(4) (text unchanged)

[I]*G.* Repealed.

[J]*H.* Special Audit.

(1)-(3) (text unchanged)

[K]*I.* Annual Reports of Wage and Salary Survey.

(1)-(4) (text unchanged)

[L]*J.* Rate Review Reports.

(1)-(2) (text unchanged)

[L-1]*J-1.* Interns and Residents Survey.

(1)-(2) (text unchanged)

[L-2]*J-2.* General Assembly Studies and Other Reports. The Commission may require hospitals to submit information in response to information required of the Commission by the Maryland General Assembly.

[L-3]*J-3.* Annual Nonprofit Hospital Community Benefit Report.

(1)-(3) (text unchanged)

[L-4]*J-4.* Internal Revenue Service Form 990. Beginning on October 1, 2009, each nonprofit hospital shall submit its most recent Form 990 that the facility filed with the Internal Revenue Service within 30 days from the Internal Revenue Service filing.

[L-5]*J-5.* Annual Debt Collection Report.

(1)-(3) (text unchanged)

[M]*K.* Report Format Changes. The Commission, after consideration at a public meeting or other public forum, may modify the reporting requirements of the above reports as it deems necessary, if reasonable notice is given to each hospital under its jurisdiction and all designated interested parties using the "Accounting and Reporting System for Hospitals".

[N]*L.* Failure to File Reports.

(1)-(6) (text unchanged)

[O]*M.* Requests for Extension of Time to File Required Reports.

(1)-(6) (text unchanged)

[P]*N.* Review of Denial of Request for Extension.

(1)-(6) (text unchanged)

[Q]*O.* Stay of Charges.

(1)-(2) (text unchanged)

John M. Colmers
Chairman
Health Services Cost Review Commission

IMPACT STATEMENTS

PART A
(check one option)

ESTIMATE OF ECONOMIC IMPACT

_____ The proposed action has no economic impact.

OR

__X__ The proposed action has an economic impact.

I. Summary of Economic Impact.

II. Types of Economic Impacts.	Revenue (R+/R-) Expenditure (E+/E-)	Magnitude
A. On issuing agency:	E+	$25,000
B. On other State agencies:	None	
C. On local governments:	None	
	Benefit (+) Cost (-)	Magnitude
D. On regulated industries or trade groups:	-	Minimal
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. The HSCRC is expanding its current data collection activity to include revenue and utilization breakouts for out-of-state and Medicare patients in monthly reporting. The HSCRC has procured technical and programming assistance for adding these web-based additional data collection components at a cost of $25,000.

D. The data already exist at hospitals. They have to be extracted in order to meet the reporting requirements. The HSCRC anticipates that the cost of extraction will be minimal.

PART B

(Check one option)

Economic Impact on Small Businesses

__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

(Check one option)

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

or

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

Opportunity for Public Comment

PART C

(For legislative use only; not for publication)

A. Fiscal Year in which regulations will become effective: FY2014

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

X YES ___ NO

C. If "yes", state whether general, special (exact name), or federal funds will be used:

HSCRC Special Funds

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

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

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

These regulations continue the status quo of providing for a revenue-neutral assessment on hospital rates, which will help fund the Maryland Health Insurance Plan.

Title 10 DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Subtitle 37 HEALTH SERVICES COST REVIEW COMMISSION

Chapter 01 Uniform Accounting and Reporting System for Hospitals and Related Institutions

Authority: Health-General Article, §§19-207, 19-211, 19-212, 19-215—19-217, 19-218, 19-220, 19-224, and 19-303, Annotated Code of Maryland

Notice of Proposed Action

The Health Services Cost Review Commission proposes to amend Regulation .**03** under **COMAR 10.37.01** Uniform Accounting and Reporting System for Hospitals and Related Institutions. This action was considered and approved for promulgation by the Commission at a previously announced open meeting held on November 6, 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 March 3, 2014.

Statement of Purpose

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

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 January 2, 2014. A hearing may be held at the discretion of the Commission

.03 Reporting Requirements; Hospitals

A.-C. (text unchanged)

D. Monthly Reports of Achieved Volumes [.] *and Revenue*.

(1) The following monthly volume *and revenue* reports to be submitted by each [Section 556] hospital *under the jurisdiction of the Commission*, with the exception of those hospitals that are a part of the Department of Health and Mental Hygiene:

(a) Statistical Data *and Revenue* Summary – Daily Hospital Services [(MS)];

(b) Statistical Data *and Revenue* Summary – Ancillary Services [(PSA, SB);]*.*

[(d) Gross Patient Revenues – (RSA, RSB, RSC);.]

(2) [Schedules MS, NS, PSA, PSB and RSA, RSB, and RSC] *The Monthly Reports of Achieved Volumes and Revenues* shall be completed on the basis of actual data in the [form] *format* prescribed by the Commission [contained in the "Accounting and Reporting System for Hospitals"].

(3) [Schedules MS, NS, PSA, PSB and RSA, RSB, and RSC] *The Monthly Reports of Achieved Volumes and Revenues* shall be submitted within 30 days after the end of each month of the calendar year in the format prescribed by the Commission.

(4) The Monthly Reports of Achieved Volumes and Revenues submitted under §D of this regulation shall be made in the format as published in the Maryland Register and on the Commission's website [http://www.hscrc.maryland.gov].

[E. Monthly Report of Rate Compliance.

(1) The following monthly report of rate compliance is required to be submitted by each Section 556 hospital, with the exception of those hospitals that are a part of the Department of Health and Mental Hygiene: Statistical Data Summary – Rate Compliance (CSA, CSB).

(2) Schedules CSA, CSB shall be completed on the basis of actual data in the form prescribed by the Commission contained n the "Accounting and Reporting System for Hospitals".

(3) Schedules CSA, CSB shall be submitted within 30 days after the end of each month of the calendar year in the format prescribed by the Commission.]

[F. Repealed.]

[G]*E.* Annual Report of Revenue and Volume Comparison.

(1)-(3) (text unchanged)

[H]*F.* Annual Reports of Revenues, Expenses and Volumes.

(1)-(4) (text unchanged)

[I]*G.* Repealed.

[J]*H.* Special Audit.

(1)-(3) (text unchanged)

[K]*I.* Annual Reports of Wage and Salary Survey.

(1)-(4) (text unchanged)

[L]*J.* Rate Review Reports.

(1)-(2) (text unchanged)

[L-1]*J-1.* Interns and Residents Survey.

(1)-(2) (text unchanged)

[L-2]*J-2.* General Assembly Studies and Other Reports. The Commission may require hospitals to submit information in response to information required of the Commission by the Maryland General Assembly.

[L-3]*J-3.* Annual Nonprofit Hospital Community Benefit Report.

(1)-(3) (text unchanged)

[L-4]*J-4.* Internal Revenue Service Form 990. Beginning on October 1, 2009, each nonprofit hospital shall submit its most recent Form 990 that the facility filed with the Internal Revenue Service within 30 days from the Internal Revenue Service filing.

[L-5]*J-5.* Annual Debt Collection Report.

(1)-(3) (text unchanged)

[M]*K.* Report Format Changes. The Commission, after consideration at a public meeting or other public forum, may modify the reporting requirements of the above reports as it deems necessary, if reasonable notice is given to each hospital under its jurisdiction and all designated interested parties using the "Accounting and Reporting System for Hospitals".

[N]*L.* Failure to File Reports.

(1)-(6) (text unchanged)

[O]*M.* Requests for Extension of Time to File Required Reports.

(1)-(6) (text unchanged)

[P]*N.* Review of Denial of Request for Extension.

(1)-(6) (text unchanged)

[Q]*O.* Stay of Charges.

(1)-(2) (text unchanged)

John M. Colmers
Chairman
Health Services Cost Review Commission

IMPACT STATEMENTS

PART A
(check one option)

ESTIMATE OF ECONOMIC IMPACT

_____ The proposed action has no economic impact.

OR

__X__ The proposed action has an economic impact.

I. Summary of Economic Impact.

II. Types of Economic Impacts.	Revenue (R+/R-) Expenditure (E+/E-)	Magnitude
A. On issuing agency:	E+	$25,000
B. On other State agencies:	None	
C. On local governments:	None	
	Benefit (+) Cost (-)	Magnitude
D. On regulated industries or trade groups:	-	Minimal
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. The HSCRC is expanding its current data collection activity to include revenue and utilization breakouts for out-of-state and Medicare patients in monthly reporting. The HSCRC has procured technical and programming assistance for adding these web-based additional data collection components at a cost of $25,000.

D. The data already exist at hospitals. They have to be extracted in order to meet the reporting requirements. The HSCRC anticipates that the cost of extraction will be minimal.

PART B

(Check one option)

Economic Impact on Small Businesses

__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

(Check one option)

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

or

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

Opportunity for Public Comment

PART C

(For legislative use only; not for publication)

A. Fiscal Year in which regulations will become effective: FY2014

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

X YES ___ NO

C. If "yes", state whether general, special (exact name), or federal funds will be used:

HSCRC Special Funds

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

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

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

These regulations continue the status quo of providing for a revenue-neutral assessment on hospital rates, which will help fund the Maryland Health Insurance Plan.

HEALTH SERVICES COST REVIEW COMMISSION
4160 Patterson Avenue, Baltimore, Maryland 21215
Phone: 410-764-2605 · Fax: 410-358-6217
Toll Free: 1-888-287-3229
hscrc.maryland.gov

TO: Commissioners

FROM: Legal Department

DATE: October 23, 2013

RE: Hearing and Meeting Schedule

Public Session:

December 4, 2013 1:00 p.m., 4160 Patterson Avenue, HSCRC Conference Room
January 9, 2014 1:00 p.m., 4160 Patterson Avenue, HSCRC Conference Room

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

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

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