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December 18, 2013

The Honorable Martin O'Malley
Governor
State of Maryland
Annapolis, MD 21401-1991

The Honorable Thomas V. Mike Miller, Jr.
President of the Senate
H-107 State House
Annapolis, MD 21401-1991

The Honorable Michael E. Busch
Speaker of the House
H-101 State House
Annapolis, MD 21401-1991

RE: Chapter 425 of the 2013 Laws of Maryland (HB 102 – BRFA), Section 8 - Legislative Report on Impact of Outpatient Tiering on Maryland's Medicaid Program

Dear Governor O'Malley, President Miller and Speaker Busch:

Pursuant to Section 8 of the Budget Reconciliation and Financing Act of 2013 ("BRFA" - Chapter 425), the Health Services Cost Review Commission ("the Commission," or "HSCRC") submits the attached consultant report on the projected impact of outpatient tiering on the Department of Health and Mental Hygiene ("DHMH").

Under the BRFA, DHMH is required to achieve $30,000,000 of General Fund savings in fiscal year 2014 from a combination of tiered rates for hospital outpatient and emergency department services and hospital update factors approved by the Commission that are lower than assumed in the Medicaid budget for fiscal year 2014. Within this mandate, the HSCRC is required to contract with an independent consultant to prepare an analysis that projects the savings Medicaid could achieve from tiered rates and the update factor in fiscal year 2014. If the projected savings are less than $30 million, the Commission is required to take one or a combination of the following actions:

- adjust the Medicaid deficit assessment so that the percentage of net patient revenue it represents equals that percentage in FY 2013;
- reduce the MHIP assessment by an amount sufficient to ensure that the combined Medicaid deficit and MHIP assessments do not exceed $518 million in FY 2014; and/or
- identify and implement other actions to provide the necessary savings.

In accordance with this mandate, the Commission procured the services of Burton Policy Consulting. The principals on this project from Burton Consulting are Alice Burton and Mary Pohl. There individuals have experience working with HSCRC, DHMH, and the Medicaid Program. It is important to note that no data are available to precisely track or assess the impact that tiering has had on Medicaid; therefore, an estimation model was required for this project. The consultants were successful in utilizing their experience to establish a methodology to determine the FY 2013 impact of the Commission's tiering policy on the Medicaid program and project the impact for FY 2014.

The consultants estimated the savings to be $5.88 million in FY 2013, and projected the FY 2014 savings to be $7.37 million - well short of the targeted $30 million.

I hope this information is useful. If you have questions regarding this report, please contact Mr. Stephen M. Ports, Principal Deputy Director, at (410) 764-2591.

Sincerely,

Donna Kinzer

Donna Kinzer
Executive Director

cc: David Romans, DBM
Simon Powell, DLS
Christi Megna, DHMH
Sarah Albert, DLS

BURTON POLICY CONSULTING

IMPACT OF OUTPATIENT TIERING ON MARYLAND'S MEDICAID PROGRAM

REPORT TO THE GOVERNOR AND GENERAL ASSEMBLY – DECEMBER 2013

REPORT PREPARED BY MARY BETH POHL

This report to Maryland's Governor and General Assembly provides the findings of an impact study required by the Budget Reconciliation and Financing Act of 2013 (House Bill 102, Section 8 of the 2013 Session of the Maryland General Assembly).

Burton Policy Consulting, LLC is an independent consulting firm that focuses on health care reform and state health policy. Burton Policy Consulting (#11-500) is a Minority Business Enterprise (MBE) in the State of Maryland, as certified by the Department of Transportation.

IMPACT OF OUTPATIENT TIERING ON MARYLAND'S MEDICAID PROGRAM

REPORT TO THE GOVERNOR AND GENERAL ASSEMBLY – DECEMBER 2013
HEALTH SERVICES COST REVIEW COMMISSION (HSCRC-14-001)

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SUMMARY OF FINDINGS

The Budget Reconciliation and Financing Act of 2013 requires the Health Services Cost Review Commission (HSCRC) to engage an independent consultant to produce a projection of the impact of outpatient Clinic and Emergency Department (ED) tiering on Maryland's Medicaid Program in FY 2014. Tiering was included in the FY 2013 and 2014 budget as a Medicaid cost containment strategy. This report provides a projection of the impact of outpatient Clinic and ED tiering on Maryland's Medicaid Program in FY 2014.

Tiering rates allows hospitals, on a cost justified basis, to charge above Health Services Cost Review Commission (HSCRC)-approved rates for higher cost settings within a rate center, while charging lower rates for lower cost settings within the same rate center. In aggregate, the hospital continues to adhere to the overall rate established by the HSCRC. Tiering is cost-neutral to the hospital and health care system, but may have differential impacts on payers based on the mix of high- and low-cost settings used by a payer's enrollees. Nine hospitals moved forward with tiering Clinic rates and two also tiered ED rates, with the tiering implemented at different times during FY 2013.

METHODOLOGY

The primary input in developing solid projections for FY 2014 savings are reliable estimates of the actual savings achieved in FY 2013. Our methodology for estimating savings was designed to address the limitations of available data by employing a methodological averaging approach by payer. Our methodology was similar to an analytic approach discussed by the Department of Budget and Management and was reviewed by HSCRC and Medicaid staff.

Projecting the impact due to tiering in FY 2014 is particularly complicated because of the Medicaid expansion that will begin in January 2014, while substantially impact Medicaid enrollment. We relied on enrollment projections and actuarial assumptions provided by DHMH in developing our model.

TIERING IMPACT ESTIMATES AND PROJECTIONS

As displayed in Figure 1, we project the FY 2014 savings to DHMH due to tiering at approximately $7.37 million in state dollars, or about 25 percent of the $30 million general fund savings assumed in the FY 2014 budget. However, we project that a majority of the savings, $5.04 million, will accrue to the Medicaid Managed Care Organizations, not directly to DHMH's budget. We project the savings due to tiering to the Mental Hygiene Administration at $2.94 million in state dollars. Our projections indicate Medicaid's FFS program expenditures increase slightly due to tiering.[1]

[1] The federal government matches dollars paid by Maryland Medicaid at approximately a 1:1 ratio. Therefore, for every $1 spent by the State of Maryland for Medicaid services, the federal government also pays $1. "Total funds"

Figure 1: Estimated Tiering Impact, FY 2013 and FY 2014 (Dollars in State Funds)

	Estimated FY 2013 Impact	Projected FY 2014 Impact
FY 2013 State Fund Impact to DHMH	**-$2.54 million**	**-$2.33 million**
Medicaid Program – Fee For Service	-$0.05 million	$0.61 million
Mental Hygiene Administration	-$2.49 million	-$2.94 million
Medicaid Program – HealthChoice	**-$3.34 million**	**-$5.04 million**
Overall Impact	**-$5.88 million**	**-$7.37 million**

Source: Burton Policy Consulting, December 2013. Analysis of HSCRC Inpatient and Outpatient Casemix Data, FY 2013 with projection assumptions.

The concept of tiering as a Medicaid cost containment initiative is premised on the fact that the Medicaid population disproportionately uses lower intensity Clinic and ED services. Our findings suggest that there are some savings as a result of tiering these rate centers. However, as Medicaid enrolls more adults, as expected under health reform, the savings from tiering, especially in the ED rate center, will erode.

includes both the state dollars and the federal match. "State dollars", "State funds", or "general funds" are only the state potion of the expenditure. In this report, we provide all figures and tables as state dollars, unless otherwise noted.

INTRODUCTION

The Budget Reconciliation and Financing Act of 2013 requires the Health Services Cost Review Commission (HSCRC) to engage an independent consultant to produce a projection of the impact of outpatient Clinic and Emergency Department (ED) tiering on Maryland's Medicaid Program in FY 2014. Tiering was included in the FY 2013 and 2014 budget as a Medicaid cost containment strategy.

Tiering rates allows hospitals, on a cost justified basis, to charge above HSCRC-approved rates for higher cost settings within a rate center, while charging lower rates for lower cost settings within the same rate center. In aggregate, the hospital continues to adhere to the overall rate established by the HSCRC. Tiering is cost-neutral to the hospital and health care system, but may have differential impacts on payers based on the mix of high- and low-cost settings used by a payer's enrollees.

BACKGROUND

HSCRC RATE SETTING AND TIERING

The State of Maryland's HSCRC sets inpatient and outpatient hospital reimbursement rates for all payers in the state. The HSCRC establishes these rates on a hospital-specific basis per unit of service by rate center. A rate center is a collection of activities, including facility use, equipment, nursing and other non-physician professional fees, and maintenance costs for a group of related hospital functions. Currently, the HSCRC has designated 64 rate centers, including Clinic and Emergency Department.[2] While hospitals must charge all payers the HSCRC-established rate for a unit of service within a given rate center, the actual cost to the hospital for providing a unit of service in one setting may differ from another setting.[3] For example:

- Clinic Rate Center: Within the Clinic rate center, hospitals fund a range of costs associated with different types of clinics. One unit of service for a specialty clinic may cost the hospital more than one unit of service at a primary care clinic. The more medically complex patients at the specialty clinic may require more time and resources than at a primary care clinic. The equipment needed, and space required, in the specialty clinic may also be more expensive than in the primary care clinic.
- Emergency Department (ED) Rate Center: Within the ED rate center, hospital costs associated with pediatric and adult ED settings differ. As hospitals triage major traumas

[2] For a full listing of rate centers (cost centers) and descriptions, see the HSCRC's website: http://www.hscrc.state.md.us/documents/Hospitals/Compliance/AccountingBudgetManual/2011/Section200-Final-08-01-11.pdf

[3] Rate orders are available on the HSCRC website at http://www.hscrc.state.md.us/hsp_Rates2.cfm

to the adult ED, one unit of service in an adult ED setting is much more costly than in the pediatric ED.

The rates established by the HSCRC blend these costs among the different clinics or ED settings to provide to the hospital an average charge amount to cover costs for all clinic services and all ED services.

TIERING ALLOWS HOSPITALS TO CHARGE MORE FOR MORE COSTLY SERVICES AND LESS FOR LESS COSTLY SERVICES

Tiering allows hospital to charge below the HSCRC-established rate for less resource-intensive services (e.g., primary care clinics within the Clinic rate center, pediatric ED within the ED rate center), while charging above the rate for more resource-intense services, such as specialty clinics within the Clinic rate center and visits to the adult ED. However, in aggregate, the hospital must adhere to the single approved HSCRC rate for the rate center, within established corridors.[4]

To comply with State and Federal law, tiering must occur by service/setting, not by payer. However, the impact of tiering may differ by payer. Figure 2 provides an example of two payers and demonstrates the impact to the payer of tiered services.

In this example, both Payer 1's and Payer 2's enrollees use 5,000 total units of service. For Payer 1, 4,000 units are high cost units of service and 1,000 are low cost units of service. Conversely, the hospital provides Payer 2's enrollees with only 1,000 units of high cost services and 4,000 units of low cost services. In the absence of tiering, both payers reimburse the same amount, $500,000 each for the 5,000 total units of service. However, when the hospital tiers the rates, Payer 1, with a population using a greater number of high cost services, reimburses $75,000 more than for the same services without tiering. Payer 2, with more patients receiving low cost services, reimburses less under the tiered rate structure. Note that tiering is cost neutral to the hospital and to the health care system.

[4] In monitoring hospital compliance, the HSCRC establishes an overcharge and undercharge corridor around each of the rate center's unit rate amount. If the hospital, in aggregate, charges within these corridors, the HSCRC does not impose penalties on the hospital for over or under changing.

Figure 2: Tiering Differentially Impacts Payers

			Not Tiered		Tiered	
		Units of Service	Charge Per Unit	Charges	Charge Per Unit	Charges
Payer 1	High Cost Service	4,000	100	$ 400,000	125	$ 500,000
	Low Cost Service	1,000	100	$ 100,000	75	$ 75,000
	Total	5,000		$ 500,000		$ 575,000
	Impact of Tiering to Payer 1					$ 75,000
Payer 2	High Cost Service	1,000	100	$ 100,000	125	$ 125,000
	Low Cost Service	4,000	100	$ 400,000	75	$ 300,000
	Total	5,000		$ 500,000		$ 425,000
	Impact of Tieing to Payer 2					$ (75,000)
Impact to System						$ 0

Source: Burton Policy Consulting, December 2013.

HISTORY OF HSCRC TIERING

In the years directly prior to FY 2013, there were only limited cases where the HSCRC allowed hospitals to tier charges within a rate center. The HSCRC permitted hospitals to tier the Same Day Surgery rate center in FY 2011 to account for movement of cases from an inpatient to an outpatient setting. Going into FY 2013, the HSCRC only permitted Bayview Medical Center to tier the Clinic rate center. This allowance was due to Bayview's assuming responsibility for city-operated substance abuse treatment clinics several years prior. Tiering, in this case, allowed for Bayview to charge substantially below average Clinic rates for the very low cost treatment services that typically would not be provided in a hospital clinic.[5]

The FY 2013 State of Maryland Budget directed the HSCRC to allow hospitals to tier Clinic and ED rates. To comply with HSCRC regulation, tiering must be cost justified (i.e., tiered rates must represent actual differences in cost by setting). The FY 2013 budget assumed this would result in $30 million in general fund savings, or $60 million in total funds. When tiering was originally included in the FY 2013 budget, there was considerable debate about whether this strategy would yield the assumed savings. The FY 2014 Budget assumed continued savings from

[5] Because this analysis quantifies the impacts the tiering actions in FY 2013 and FY 2014, we did not account for the previously tiered rates at Bayview. Increased or decreased use of these settings will impact Medicaid; however, we do not address that impact in this report.

tiering; in addition, it also required the HSCRC to engage an independent consultant to produce a projection of the FY 2014 impact on the Medicaid Program from tiered rates in FY 2014.

In a memo dated June 11, 2012, the HSCRC "urged hospitals that experience high Medicaid volumes in the Clinics and EDs" to tier these rate centers beginning July 1, 2012. Cost justification of a hospital's tiered structure is paramount to compliance with HSCRC regulation and statute. Therefore, to participate in the tiering, the HSCRC required the hospitals to submit documentation of cost justification along with the request to tier. Nine hospitals found cost justification and requested to tier Clinic rates. Two of the hospitals, Johns Hopkins Hospital and University of Maryland Medical System, also requested to tier ED rates. Several other hospitals (Saint Agnes, the non-tiering MedStar facilities, the non-tiering UMMS facilities, and Western Maryland Health System) communicated with HSCRC that cost analysis did not justify tiering. We have provided copies of hospitals' requests to tier and HSCRC's tiering approval memos in this report's Appendix.

Figure 3 indicates the hospitals that engaged in tiering and the settings tiered.

Figure 3: Hospitals Engaging in Clinic and ED Tiering in FY 2013 and FY 2014

	Clinic		ED	
	Low Tier	*High Tier*	*Low Tier*	*High Tier*
Doctors Community Hospital *Initiated Tiering 9/1/2012*	Cardiac and Pulmonary Rehabilitation	All Other Clinics		
Johns Hopkins Hospital *Initiated Tiering 7/1/2012 (Clinic), 11/15/2012 (ED)*	OB/GYN, Pediatric Primary Care, Medicine, Psychiatric, Infusion	All Other Clinics	Pediatric ED	Adult ED
Johns Hopkins Bayview *Initiated Tiering 7/1/2012*	Psychiatric, Infusion, Pediatric	All Other Clinics		
LifeBridge Health Northwest Hospital *Initiated Tiering 10/4/2012*	Infusion, Pharmacy Clinic	Wound Care, Infusion, Nutrition, Cardiac and Pulmonary Rehabilitation		
LifeBridge Health Sinai Hospital *Initiated Tiering 10/18/2012*	Infusion, Anticoagulation, Diabetes, Retina, Psychiatric, Addictions Recovery	Infectious Disease, Pediatric, Ophthalmology,		
MedStar Franklin Square Medical Center	Psychiatric	All Other Clinics		

	Clinic		ED	
	Low Tier	*High Tier*	*Low Tier*	*High Tier*
Initiated Tiering 8/30/2012				
UMMS *Initiated Tiering 8/9/2012 (Clinic), 8/21/2012 (ED)*	Psychiatric, Pediatric Hem/ Infusion, Addiction Treatment, Ophthalmology	All Other Clinics	Pediatric ED	Adult ED
UMMS Midtown *Initiated Tiering 8/21/2012*	Family Health, Diabetes, Psychiatric, Pain	All Other Clinics		
UMMS Rehabilitation and Orthopedic *Initiated Tiering 7/1/2012*	Dental	All Other Clinics		

Source: Burton Policy Consulting, December 2013. Analysis of HSCRC tiering memos and email communication beginning June 2012.
Notes: Table based on documents provided by hospitals to the HSCRC upon the initiation of tiering. Original documentation from UMMS in July 2013 indicates tiering at UMMS Baltimore Washington Medicaid Center; however, this hospital is not presented in as a tiered hospital in subsequent HSCRC or hospital documentation.

SAVINGS ESTIMATES

FY 2014 PROJECTIONS RELY ON ESTIMATES OF FY 2013 SAVINGS ACHIEVED

The primary input in developing solid projections for FY 2014 savings is to establish reliable estimates of the actual savings achieved in FY 2013. Estimating savings in FY 2013 is a complex task because there is limited data on the utilization of different types of clinic or ED services (i.e., the use of high cost settings vs. low cost settings within a rate center).[6]

METHODOLOGY

After reviewing several potential options to address the lack of data, we selected and employed a methodological averaging approach by payer to produce the tiering estimates for FY 2013. This approach determines the average unit rate that the hospital charges to each payer grouping and compares that to the average unit rate charged across all payers. Figure 4 outlines our methodology. We applied this methodology in an Excel-based model.

[6] HSCRC data indicates units of service in each rate center but does not disaggregate into the clinic or ED settings.

Figure 4: Methodology Employed to Develop FY 2013 Estimates

Step	Description	Notes
1	Select inpatient admissions and outpatient visits from the tiered hospitals for which the record has units and charges in the Clinic and/or ED rate center	Performed in HSCRC data extraction
2	Assign each record a mutually exclusive payer grouping, as discussed below	
3	Sum the clinic units and charges by payer grouping; sum the ED units and charges by payer grouping for ED tiered hospitals	
4	• For each hospital, by Clinic and ED rate center, compute the average charge per unit of service across all payer groupings • Within each hospital, by rate center and payer grouping, compute the average charge per unit of service • Separately for the ED and Clinic rate center: The difference between the overall hospital average charge per unit of service and the average charge per unit of service for the payer grouping is the impact of tiering per unit of service.	
5	Multiply the impact of tiering per unit of service by the number of units by payer grouping	
6	Johns Hopkins Bayview Medical Center tiered behavioral health services prior to FY 2013. In FY 2013, Bayview applied tiers rates for some primary care clinics. Prior to applying the methodology described in Steps 4 and 5, we removed behavioral health services from our analysis of Bayview to isolate the impact of tiering of primary care clinics.	Bayview alternative methodology
7	Sum across hospitals to determine the overall impact to charges	
8	Move from charges to estimated reimbursement: • Dual eligibles: Medicaid's cost sharing is 20 percent of charges. Multiply the total impact by 0.2 to determine charges to Maryland Medicaid. • Medicaid FFS reimburses 94 percent of charges, while Medicaid MCOs reimburse 96 percent of charges. Multiple the impact in charges to determine reimbursement amount.	
9	State share is approximately 50 percent of the reimbursement amount. Multiple the reimbursement total by 0.5 to determine the total impact to DHMH in state dollars. • Allocate reimbursements for behavioral health carve out to the Mental Hygiene Administration's budget • Allocate reimbursements for Medicaid FFS, Medicaid managed care, and the Dual eligible population to the Medicaid Program	

Source: Burton Policy Consulting, December 2013.

The methodology we employed is similar to an analytic approach discussed by HSCRC staff and Department of Budget and Management officials in November 2012.[7] This approach has a major advantage over other methodologies as it does not rely on individual visit-level details to differentiate between the different settings (i.e., we do not need to know in which clinic setting the patient was served). Neither HSCRC data nor Medicaid claims/encounter data indicate in which setting a hospital performs a clinic or ED service. While for ED services, we can establish a proxy setting based on the age of the patient to attempt to differentiate the pediatric vs. adult ED setting, an averaging approach accounts for use of the adult ED by pediatric patients. In addition, the averaging approach employed does not rely on an input of the tiered rates by setting. As hospitals fluctuate rates during a rate year, a methodology that does not incorporate the rates themselves significantly simplifies the analysis and improves the estimate's accuracy. We provided the HSCRC Excel versions of the model developed for this report.

DATA

Hospitals submit records of every inpatient discharge and outpatient visit on a quarterly basis to the HSCRC.[8] Our team conducted the analysis for this report in October and November 2013 using FY 2013 HSCRC discharge and visit data.[9] HSCRC staff programmed and performed the data extraction from discharge/visit-level HSCRC datasets and provided to us the raw aggregated data files.[10] Figure 5 summarizes the units of service and charges by rate center used in this analysis.

Figure 5: Clinic and ED Data Employed in the FY 2013 Impact Estimates

Rate Center	Units of Service			Charges
	Total	*% Outpatient*	*% Inpatient*	
Clinic	6,628,969	98%	2%	$283,047,144
ED	1,829,482	77%	23%	$147,543,692

Source: Burton Policy Consulting, December 2013. Analysis of HSCRC Inpatient and Outpatient Casemix Data, FY 2013.

[7] HSCRC used this approach to produce an estimate of the FY 2013 Quarter 1 impact of tiering. As a majority of hospitals did not have their tiering structures in place at the beginning of FY 2013 Q1, the early HSCRC estimates used FY 2013 Q1 estimates and layered hospitals projections for tiering savings to project savings for FY 2013.

[8] In FY 2014, the HSCRC will begin collecting monthly hospital data.

[9] While Clinic and ED rate centers are predominately considered outpatient services, for this analysis, we found it more complete to include both inpatient and outpatient HSCRC data. The HSCRC data would capture outpatient clinic or ED visits on an inpatient record if a patient was hospitalized immediately subsequent to the outpatient visit. While including inpatient records in the analysis provides minor impact for the Clinic rate center, we found that, understandably, there is a more significant volume of ED units of service and charges carried on the inpatient records. (Likely these are cases in which an individual enters the hospital through the ED and is then admitted for inpatient services.) Note that while we present annual FY 2013 estimates in this report, we conducted our analysis using quarterly data. The quarterly estimates served to inform our FY 2014 projections.

[10] As the HSCRC relies heavily upon these datasets for rate setting, audits and reviews have found HSCRC data reliable for accurately reflecting charges at Maryland's acute care hospitals.

PAYER GROUPINGS

The methodology discussed above relies on the division of data into payer groupings. Our original modeling accounted for only three payer groups. We divided records into the mutually exclusive groups of Medicaid fee for service, Medicaid Managed Care, and All Others based on the Primary Payer value in the HSCRC datasets. However, feedback from Medicaid and MCO officials requested the ability to differentiate between services that would impact the Medicaid Program and the Mental Hygiene Administration budgets. We analyzed the primary ICD-9 codes in HSCRC's data to indicate when a service is considered a behavioral health carve out and reimbursed from the Mental Hygiene Administration program budget.[11] In addition, as Medicaid reimburses for cost sharing for Medicare-Medicaid Dual eligible enrollees, we also revised our original analysis to account for the impact of tiering on the Dual eligible population.[12] This required use of the HSCRC's Secondary Payer variable. As this analysis intends to capture impact to Maryland's Medicaid program (e.g., not Pennsylvania's or the District of Columbia's Medicaid program), we also grouped all individuals indicating out of state addresses into the "All Other" payer grouping. For the tiered hospitals, we identified 328,573 units of Clinic and 80,293 units of ED services with the out of state addresses and moved these units and charges into the "All Other" payer grouping. See Figure 6.

Maryland Medicaid also administers the Primary Adult Care program (PAC), a reduced scope benefit package that covers limited outpatient hospital care, namely ED visits and mental health clinic services. When hospitals submit data to the HSCRC, hospitals code visits reimbursed by PAC as "Medicaid managed care." Therefore, our payer groupings of "Medicaid Managed Care" and "Medicaid Managed Care-Behavioral Health Carve Out" include PAC.

[11] COMAR 10.09.70.10 lists the ICD 9 diagnoses codes for carved out behavioral health services.

[12] We attributed the total impact of tiering among the Dual Eligible population to Medicaid fee for service. In practice, some of the impact could fall on the Mental Hygiene Administration budget. However, as we estimated the overall impact of Duals is minor, we opted to not further subdivide this grouping.

Figure 6: Payer Groupings for the FY 2013 Tiering Estimate

Source: Burton Policy Consulting, December 2013.

FINDINGS - ESTIMATE OF FY 2013 SAVINGS REALIZED

Our analysis estimates that the savings from tiering Clinic and ED rate centers to DHMH totaled $5.88 million in state funds. Of this total savings, our analysis attributes $2.49 million in savings to the Mental Hygiene Administration and $3.39 million to the Medicaid Program.[13,14] However, all of the Medicaid savings accrue to Medicaid's Managed Care Organizations (MCOs). For DHMH to realize these savings, Medicaid would need to account for the estimated savings in MCO rate structures.[15]

Note that this analysis assumes that payers reimburse all charges at the designated rates (94 percent for Medicaid fee for service, 96 percent for Medicaid MCOs). Especially in the case of

[13] We present all findings in state fund dollars (excluding federal cost sharing), unless otherwise noted.
[14] Tiering negligibly impacted the Medicare-Medicaid Dual eligible population.
[15] In this report, we provide savings estimates in state funds; therefore, Medicaid would need to account for approximately double this amount in the MCO rates to recover the total fund amount.

non-emergency ED services, the payer in practice may not reimburse for the rate center charges above the triage fee. If Maryland Medicaid uses these estimates to make adjustments to MCO rates, they may want to consider requesting further data from the MCOs to assess the extent to which ED rate center charges are not reimbursed and determine the potential impact on MCO rates. Our analysis also did not make adjustments for GME discounts which apply to MCO payments to some Maryland hospitals. DHMH may want to consider further analysis of GME discounts, if the Program uses these report findings to adjust MCO rates.

Figure 7 displays the differential impact of tiering in the Clinic and the ED rate centers. The Clinic rate center provided approximately 70 percent of the overall savings, with ED rate tiering accountable for the remaining savings.

Figure 7: Estimated Tiering Impact by Clinic and ED Rate Centers, FY 2013 (Dollars in State Funds)

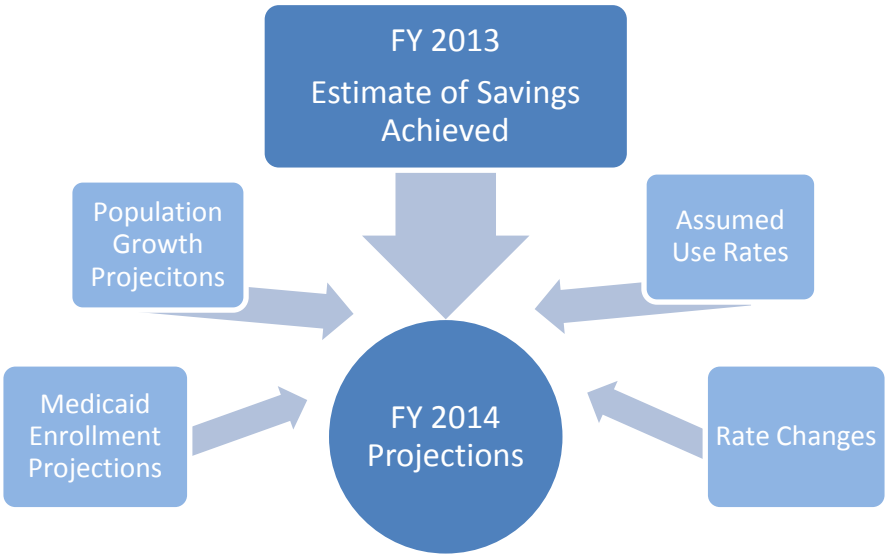
	Clinic Impact	ED Impact	Impact from ED and Clinic
FY 2013 State Fund Impact to DHMH	**-$2.57 million**	**$0.03 million**	**-$2.54 million**
Medicaid Program – Fee For Service	-$0.15 million	$0.10 million	-$0.05 million
Mental Hygiene Administration	-$2.43 million	-$0.06 million	-$2.49 million
Medicaid Program – HealthChoice	**-$1.66 million**	**-$1.69 million**	**-$3.34 million**
Overall Impact	**-$4.23 million**	**-$1.65 million**	**-$5.88 million**

Source: Burton Policy Consulting, December 2013. Analysis of HSCRC Inpatient and Outpatient Casemix Data, FY 2013.
Notes: Figures may not sum due to rounding;
All dollars are state fund dollars. We exclude federal cost sharing during the analysis;
Negative dollars are savings, while positive dollars are increased expenditures;
Dollars attributable to Medicaid's HealthChoice program do not directly accrue to the General Fund. To capture these savings, the Medicaid Program would need to account for the savings in MCO rate structures in subsequent years.

PROJECTIONS OF FY 2014 SAVINGS

Projecting the impact of outpatient hospital rate tiering for FY 2014 is complex, especially as this is a dynamic period for Medicaid enrollment. We do not yet have data for FY 2014; therefore, we cannot employ the averaging methodology that we used to develop the FY 2013 impact estimates. As displayed in Figure 8, projecting the impact for FY 2014 instead relies on projecting forward the baseline of savings that were achieved in FY 2013 by applying a number of assumptions to the baselines. This section reviews some of the complexities of producing the impact projections, outlines the methodology we applied, and provides our FY 2014 impact projections.

Figure 8: FY 2014 Projections Build on FY 2013 Estimates



Source: Burton Policy Consulting, December 2013.

PROJECTION BARRIERS

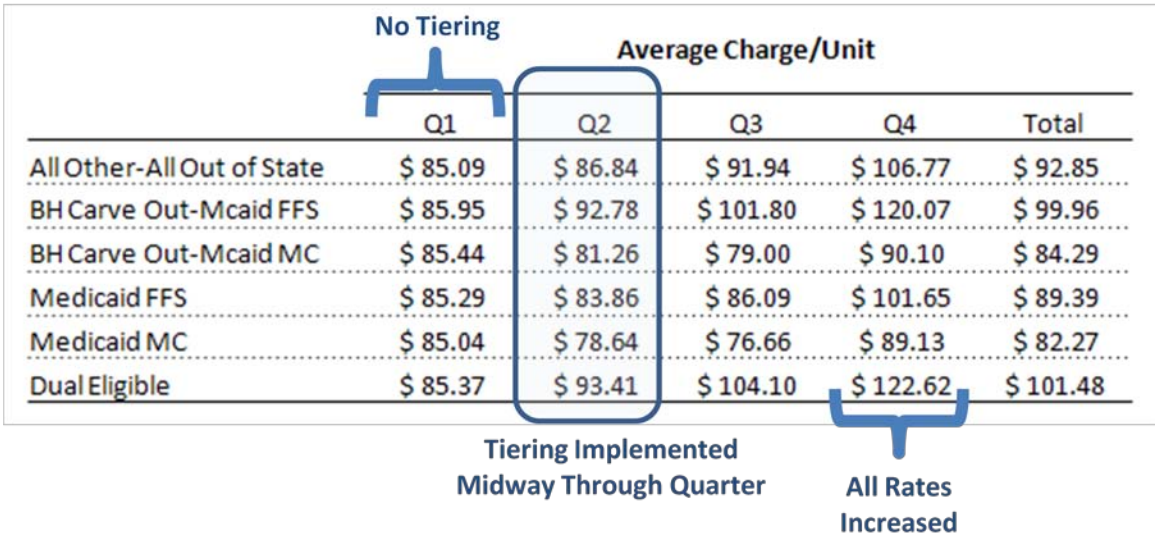
Ideally, after establishing the FY 2013 estimates, these annual figures would serve as our baseline and we would apply cost and volume growth assumptions for a fairly straightforward projection methodology. However, both in establishing the baseline and in applying assumptions, we identified a number of barriers.

FY 2013 BASELINE SAVINGS DO NOT REFLECT AN ENTIRE YEAR OF TIERING

Foremost, our review of FY 2013 estimates by quarter clearly demonstrated the inaccuracy of using the complete year as a baseline for projecting the FY 2014 impact. Nine hospitals implemented teiring in FY 2013 at different points during the first two quarters of FY 2013, not at the start of the year. In most cases, the hospitals implemented during in the middle of a fiscal quarter. In addition, documentation provided by the HSCRC indicates that several hospitals, after re-reviewing cost data, altered the tiering structure during the fiscal year.

Other system dynamics not related to tiering also cause quarterly fluctuations in the FY 2013 baseline. For example, during FY 2013, UMMS shifted clinic rates to account for cost reclassifications. UMMS also moved entire clinics from UMMS University Specialty Hospital to UMMS Midtown. Further, we see from the FY 2013 quarterly projections that hospitals adjusted rates during the year for projected under/overcharging, especially during quarter 4. See Figure 9 for an example of the variability of rates charged from quarter to quarter.

Figure 9: FY 2013 Tiering Impact Estimates Vary Across Quarterly Data, Johns Hopkins Hospital ED



	Q1	Q2	Q3	Q4	Total
All Other-All Out of State	$ 85.09	$ 86.84	$ 91.94	$ 106.77	$ 92.85
BH Carve Out-Mcaid FFS	$ 85.95	$ 92.78	$ 101.80	$ 120.07	$ 99.96
BH Carve Out-Mcaid MC	$ 85.44	$ 81.26	$ 79.00	$ 90.10	$ 84.29
Medicaid FFS	$ 85.29	$ 83.86	$ 86.09	$ 101.65	$ 89.39
Medicaid MC	$ 85.04	$ 78.64	$ 76.66	$ 89.13	$ 82.27
Dual Eligible	$ 85.37	$ 93.41	$ 104.10	$ 122.62	$ 101.48

Source: Burton Policy Consulting, December 2013. Analysis of HSCRC Inpatient and Outpatient Casemix Data, FY 2013.

HEALTH REFORM WILL IMPACT MEDICAID ENROLLMENT

In addition to the baseline challenges, the Medicaid expansion that will begin in January 2014 will impact Medicaid enrollment. Medicaid enrollment projections serve as a fundamental input for projecting the impact of tiering in FY 2014, with a majority of the enrollment growth expected mid-fiscal year (i.e., tiering projections rely on Medicaid's enrollment projections). Complicating the financial projections, PAC-enrolled individuals in the FY 2013 baseline received 50 percent state and 50 percent federal funding. However, these individuals will move to 100 percent federal funding midway through FY 2014 when enrolling in the full Medicaid benefit package. This presents a challenge with restating projections based on hospital charges to general fund dollars.

METHODOLOGY

After reviewing potential projection options, we selected and employed the methodology outlined below. We determined that this methodology would best project the impact in FY 2014 while mitigating the barriers described above. In this approach, we determine, by hospital, a "steady state" quarter to serve as the basis for projections. In some hospitals the "steady state" quarter was an average across several quarters. The methodology varied slightly when applied to each hospital based on characteristics of the hospital's tiering structure and/or to compensate for missing or erroneous input values. Figure 10 outlines our methodology. We applied this methodology in an Excel-based model.

Figure 10: Methodology Employed to Develop FY 2014 Projections

Step	Description	Data Inputs
	Basic Methodology	
1	**Select a "steady state" quarter:** From the FY 2013 estimates, we reviewed each hospital's quarterly data to identify a quarter that appeared to have fully implemented tiering. For most hospitals this was quarter 3 or quarter 4. For some hospitals, it was the average across several quarters.	FY 2013 quarterly impact estimates
2	**Allocate the units of service across tiered rate groupings:** Using known tiered rates, we use an algebraic equation to solve for the number of units of service provided by tier.	Tiered rates provided by hospitals to the HSCRC; assumed rates when rates were missing or erroneous
3	**Project the units of service in FY 2014 based on enrollment growth:** • Annualize the single quarter estimates from Step 2. • For the "All Other" group, apply Maryland population growth projections. For the other groupings, apply data from Medicaid enrollment projections. Based on discussions with Medicaid, the Medicaid actuary projects negligible volume growth beyond enrollment growth. Therefore, this analysis does not built in an adjustment factor for additional volume.	Maryland population growth, Medicaid enrollment projections
4	**Project FY 2014 tiered rates:** Volume, tiered rates, and the hospital's rate center rate (set by the HSCRC) have a defined relationship. Holding constant the FY 2014 rate center rate (from the rate order) and the ratio of high cost to low cost tiers in FY 2013, solve for the FY 2014 rates. This accounts for price growth and feedback.	HSCRC rate orders, Ratio of low to high tiered rates from FY 2013
5	**Calculate impact in charges:** Multiply the units by the tiered unit rate to project the total charges. We apply the methodology developed for the FY 2013 impact estimates, including the movement from charges to reimbursement and from reimbursement to state dollars. However, in FY 2014, we must account for the PAC populations moving into 100 percent federal funding. Using Medicaid's average annual enrollment projections, we calculate an estimated state share and apply this to the reimbursement projections.	Medicaid enrollment projections
	Deviations from Basic Methodology *To compensate for barriers encountered in applying this methodology, we varied the approach based on characteristics of the hospital's tiering structure and/or to compensate for missing or erroneous input values.*	
	Doctors Community Hospital: Based on FY 2013 estimates, Doctors Community Hospital has a negligible impact on tiering. After selecting the best representative quarter of FY 2013 data, we annualized the "steady state" quarter and applied a price growth factor to determine projected FY 2014 impact.	

Step	Description	Data Inputs
	Johns Hopkins Bayview: We applied a price growth based on HSCRC FY 2014 rates over FY 2013 rates. Then we applied an average percent impact of Medicaid FFS and Medicaid managed care enrollment growth based on JHH and UMMS clinic projections.	
	Johns Hopkins – ED, UMMS – ED: For ED, we divided the Medicaid coverage groups by adult vs. child and used this as a proxy of tiered service utilization in the adult ED tier and child ED tier.	
	LifeBridge Sinai, LifeBridge Northwest, MedStar Franklin Square: Due to the multiple tiered levels at the LifeBridge facilities, it was not possible to solve for the tiered rate units (Step 2). We applied price growth based on HSCRC FY 2014 rates over FY 2013 rates. With a majority of the tiering impact in these hospitals attributed to behavioral health, we could not apply Medicaid impact rates from JHH and UMMS clinic projections as we did for other hospitals.	
	UMMS Orthopedics and Rehabilitation and UMMS Midtown: Tiered rates in Q4 were not available. We instead applied a price growth based on HSCRC FY 2014 rates over FY 2013 rates. Then we applied an average percent impact of Medicaid FFS and Medicaid managed care enrollment growth based on JHH and UMMS clinic projections.	
	UMMS and UMMS-ED: Solving for tiered rate units in Step 2 produced illogical results (e.g., negative units, ratios dissimilar to FY 2011 hospital data). After conducting a number of tests, we concluded that UMMS' adjustment of tiered rates occurred mid-quarter. To compensate we applied a relative percentage to the average rate (i.e., set high tier set at +10% from average and low tier set at -30% of average). Resulting distributions from this assumptions resembled distributions by setting provided by UMMS in documentation provided by the HSCRC from FY 2011 data.	

Source: Burton Policy Consulting, December 2013.

DATA

FY 2013 estimates serve as the baseline for this analysis. For assumption inputs, we employed monthly average Medicaid FY 2013 enrollment estimates and monthly average Medicaid FY 2014 enrollment projections provided by the Medicaid Program. Medicaid's consultant at the Hilltop Institute provided actuarial analysis for use rates above enrollment growth. For overall population growth, we applied Census projections by age cohort. The HSCRC provided memos documenting some of the hospital's tiered rates. We also downloaded the HSCRC's FY 2014 rate orders. In addition, we reviewed HSCRC Clinic and ED rate center trend data FY 2010 to FY 2013; however, we did not include this information in the analysis.

FINDINGS OF THE FY 2014 TIERING IMPACT ASSESSMENT

The State of Maryland's FY 2014 budget assumed $30 million in continuing savings to DHMH due to tieirng. As displayed in Figure 11, we project the FY 2014 savings due to tiering at approximately $7.37 million in state funds, about 24.6 percent of the amount assumed in the FY 2014 budget.

Of this total savings, our projections attribute $2.94 million in savings to the Mental Hygiene Administration and $4.43 million to the Medicaid Program (fee for service at $0.61 and MCO at -$5.04). Similar to the FY 2013 estimates, all of the Medicaid savings accrue to Medicaid's

managed care organizations. For DHMH to realize these savings, Medicaid would need to account for them in MCO rate structures.[16] Our projections find a modest increase in expenditures due to tiering to Medicaid's fee for service program. Figure 11 displays the differential impact.

Figure 11: Summary of Tiering Impact Estimates, FY 2014 (Dollars in State Funds)

	Clinic Impact	ED Impact	Impact from ED and Clinic	% of Assumed Savings
FY 2013 State Fund Impact to DHMH	**-$3.00 million**	**$0.68 million**	**-$2.33 million**	
Medicaid Program – Fee For Service	-$0.16 million	$0.76 million	$0.61 million	
Mental Hygiene Administration	-$2.85 million	-$0.09 million	-$2.94 million	
Medicaid Program–HealthChoice	**-$2.58 million**	**-$2.46 million**	**-$5.04 million**	
Overall Impact	**-$5.59 million**	**-$1.78 million**	**-$7.37 million**	**24.6% of $30 million**

Source: Burton Policy Consulting, December 2013. Analysis of HSCRC Inpatient and Outpatient Casemix Data, FY 2013 with projection assumptions.

Notes: Figures may not sum due to rounding;
All dollars are state fund dollars. We exclude federal cost sharing during the analysis;
Negative dollars are savings, while positive dollars are increased expenditures;
Dollars attributable to Medicaid's HealthChoice program do not directly accrue to the General Fund. To capture these savings, the Medicaid Program would need to account for the savings in MCO rate structures in subsequent years.

ANALYSIS OF THE FY 2014 TIERING IMPACT PROJECTIONS

The FY 2014 projections indicate a 25 percent increase in savings over the FY 2013 estimates. A number of competing factors influence the savings increase. First, we anticipate the FY 2014 savings to DHMH to be larger than in FY 2013 because the nine hospitals have tiering in place from the beginning of the fiscal year and a full year of savings can be realized. In addition, we expect to see the impact of price inflation as the HSCRC increased rates by 1.65 percent at the beginning of FY 2014.

On the other hand, Medicaid projects enrollment in the January 2014 Medicaid expansion to be predominately adults. Adult enrollment actually drives down Medicaid savings from tiering. The impact is especially evident in the ED rate center as the newly enrolled adults will exclusively use the adult ED setting—the higher cost tiered setting, not the lower cost pediatric ED. To assess this impact, we reconstructed the FY 2014 tiering analysis at the Johns Hopkins Hospital ED to separate the savings in the first two quarters of FY 2014 (prior to enrollment of the health

[16] In this report, we provide savings estimates in state funds; therefore, Medicaid would need to account for approximately double this amount in the MCO rates to recover the total fund amount.

reform Medicaid populations) and the second two quarters of FY 2014 (when the Medicaid expansion will have been implemented).[17] As anticipated, we found that the projected savings in the first two quarters of the year is larger than the projected savings in the second two quarters of the year. This finding is important when developing budget assumptions for subsequent years.

[17] Johns Hopkins ED accounts for about 70 percent of the ED tiering savings. We also selected Johns Hopkins for this quarterly analysis because the tiered rates appear more stable across the FY 2013 quarters than at UMMS. The tiered rate stability lends to a more straightforward analysis.

ASSUMPTIONS AND LIMITATIONS

The FY 2013 estimates and FY 2014 projections developed in this report rely upon the best information and knowledge available at the time of analysis. Our consulting team employed our knowledge of HSCRC and Medicaid policy, as well as information gathered from meetings, discussions, and email exchanges with HSCRC, Medicaid, and hospital staff. One MCO also contributed to the analysis. HSCRC, Medicaid, and the Hilltop Institute staff provided comment of the report prior to finalization. While we have provided here a robust analysis to produce the FY 2013 estimates and FY 2014 projections, the depth of analysis is limited by the availability of data.

The FY 2013 impact of Clinic and ED tiering estimates rely on at least the following assumptions:

- Hospitals reporting of FY 2013 inpatient and outpatient case mix data to the HSCRC is accurate and complete, including:
    - Primary payer with out of state addresses are paid by other of state Medicaid programs;
    - PAC visits coded by hospitals as Medicaid MCO;
    - Complete secondary payer coding;
- HSCRC data coding and processing is accurate and complete;
- Medicaid/Medicaid MCOs paid the charges as submitted by the hospitals. There is some concern that in the ED rate center a portion of charges are reimbursed only at a lower triage fee, not as the complete charges as indicated in the HSCRC datasets. We conducted a sensitivity test showing that if half of the ED charges on the outpatient records were entirely not reimbursed, the impact of tiering in the ED rate center would diminish by approximately one third;
- Johns Hopkins Bayview Medical Center FY 2012 tiering levels would have remained constant if not for additional clinic tiering implemented in FY 2013;
- Compensation for rate overages/underages in FY 2013 accrues as price impacts in the subsequent year. We did verify that the average rates in the analysis were consistent with the published rate order amounts.

The FY 2014 impact of Clinic and ED tiering projections rely on at least the following assumptions:

- The FY 2013 rate estimates well represent actual savings to DHMH;
- New Medicaid enrollees continue to follow the use patterns of prior enrollees (based on Medicaid's actuarial analysis);
- Number and mix of clinics remains constant (e.g., clinics do not move between hospitals, additional clinics are not regulated);

- The tiered ratio of high cost to low cost settings remains constant;
- FY 2014 rates continue at 1.65 percent increase over FY 2013. The analysis does not account for mid-year HSCRC rate changes which will adjust for FY 2013 overages/underages, penalties, quality scaling, etc.;
- Johns Hopkins Bayview Medical Center tiering levels from FY 2012 would have continued to remain constant;
- Enrollment (PAC vs other Medicaid) produces a reasonable approximation for state vs federal share;
- Impact to savings from increased Medicaid enrollment in Medicaid FFS and Medicaid managed care at the Johns Hopkins Hospital and UMMS clinics rate center are representative of the impact at other hospitals for clinic.

Note that other dynamics of the rate setting system, including any regulation of clinic services and the employment of physicians by hospitals, are outside the scope of this analysis.

APPENDIX – MEMORANDUMS

URGENT

To: Chief Financial Officers – All Hospitals

From: Patrick Redmon, Executive Director

Date: June 11, 2012

Re: Tiering of Clinic and Emergency Department Rates

The FY 2013 Medicaid Budget anticipates cost containment from HSCRC policy changes in lieu of outpatient coverage reductions by Medicaid, i.e., restricting coverage for Medicaid patients to a prescribed number of outpatient visits. Since Medicaid recipients are high users of relatively low severity outpatient services, one contemplated cost containment measure involves permitting the tiering of Clinic and Emergency Departments (EMG) rates based on relative direct costs.

Therefore, the HSCRC urges hospitals that experience high Medicaid volumes in their Clinics and ERs to participate in this initiative beginning July 1, 2012.

In order to participate, hospitals will be required to submit a written request and provide analyses that substantiate on a cost basis the tiering of low cost clinics. In the case of EMGs, hospitals must be able to provide cost-based rationale for tiering their EMGs based on relative direct cost, e.g., adult versus pediatric, etc., or non-critical patients (not likely to be admitted) versus critical patients (with a good chance to be admitted). Attached you will find the format for the analyses. We would like to receive the tiering requests and analyses by June 29, 2012. You will be advised in writing shortly thereafter whether your hospital is granted approval to tier its Clinics and/or its EMG.

APPENDIX - MEMORANDUMS

LIFEBRIDGE HEALTH

2401 West Belvedere Avenue
Baltimore, MD 21215-5271

June 28, 2012

Mr. Dennis Phelps
Associate Director, Audit and Compliance
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Mr. Phelps:

Attached please find our Clinic Tiering Analyses for both Sinai and Northwest. This analysis is to substantiate the cost basis for tiering low cost clinics. We are not submitting a rationale for EMGs at this time. Neither facility has a separate cost structure for pediatrics vs adult or non-critical patients.

If you need additional information, please contact me at 410-323-4430.

Sincerely,

Kathleen Ring, CPA
Corporate Director
Reimbursement and Regulatory Reporting

APPENDIX - MEMORANDUMS

July 13, 2012

Kathleen Ring
Corporate Director
Reimbursement and Regulatory Reporting
LifeBridge Health
2401 W. Belvedere Avenue
Baltimore, Maryland 21215-15271

Dear Ms. Ring:

I am writing in response to your request to tier the Clinic Department facility fees at Sinai Hospital and Northwest Hospital Center based on relative cost. Your request has been approved effective July 1, 2012.

The Hospitals will be notified of any additional reporting requirements associated with the approved tiering. While it is anticipated that tiering of clinics and emergency department rates will be permitted beyond FY 2013, you will be notified as to whether the approval to tier extends beyond FY 2013.

If you have any questions concerning the above, you may contact me at 410-764-2565.

Sincerely,

Dennis N. Phelps
Associate Director,
Audit & Compliance

APPENDIX - MEMORANDUMS

UNIVERSITY of MARYLAND MEDICAL SYSTEM

June 29, 2012

Mr. Dennis Phelps
Associate Director
Audit & Compliance
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Re: University of Maryland Medical System – Tiering of Clinic and Emergency Department Rates

Dear Dennis:

University of Maryland Medical System (UMMS) would like to request participation in HSCRC's initiative to tier Clinic and Emergency Department Rates for those hospitals identified below.

Hospital ID	UMMS Hospital	Clinic	Emergency
210002	University of Maryland Hospital	**Request**	**Request**
210058	James Lawrence Kernan Hospital	**Request**	No Request
210038	Maryland General Hospital	**Request**	No Request
210043	Baltimore Washington Medical Center	**Request**	No Request
210035	Civista Medical Center	No Request	No Request
210037	Memorial Hospital at Easton	No Request	No Request
210010	Dorchester General Hospital	No Request	No Request
210030	Chester River Hospital Center	No Request	No Request

APPENDIX - MEMORANDUMS

June 29, 2012
Re: University of Maryland Medical System – Tiering of Clinic and Emergency Department Rates

Please find attached cost analysis for those UMMS hospitals requesting approval to participate in Medicaid cost containment measures by tiering rates based on Medicaid volumes and low cost clinics. For those hospitals not requesting participation, this was a result of findings of low Medicaid volumes and/or no cost basis.

If you have any questions in reference to this request, please feel free to contact either me at 410-328-1380 or Bob Jackson at 410-328-4022.

Sincerely,

Alicia Cunningham
Vice President of Reimbursement
& Revenue Advisory Services

Enclosures

cc: Hank Franey, University of Maryland Medical System
Keith Persinger, University of Maryland Medical Center
Walter Augustin, James Lawrence Kernan Hospital
Brian Bailey, Maryland General Hospital
Al Pietsch, Baltimore Washington Medical Center
Michael Wood, University of Maryland Medical System
Robert Jackson, University of Maryland Medical System
Kelly Henneman, University of Maryland Medical System

APPENDIX - MEMORANDUMS

July 13, 2012

Alicia Cunningham
Vice President of Reimbursement
& Revenue Advisory Services
University of Maryland Medical System
250 W. Pratt Street, 24th Floor
Baltimore, Maryland 21201-1595

Dear Ms. Cunningham:

I am writing in response to your request to tier the Clinic and Emergency Department facility fees at University of Maryland Hospital, as well as the Clinic Department facility fees at James Lawrence Kernan Hospital, Maryland General Hospital and Baltimore Washington Medical Center based on relative cost. Your request has been approved effective July 1, 2012.

The Hospitals will be notified of any additional reporting requirements associated with the approved tiering. While it is anticipated that tiering of clinics and emergency department rates will be permitted beyond FY 2013, you will be notified as to whether the approval to tier extends beyond FY 2013.

If you have any questions concerning the above, you may contact me at 410-764-2565.

Sincerely,

Dennis N. Phelps
Associate Director,
Audit & Compliance

APPENDIX - MEMORANDUMS

DOCTORS COMMUNITY HOSPITAL
8118 Good Luck Road
Lanham, Maryland 20706-3996
301-552-8118

April 11, 2012

Health Services Cost Review Commission
c/o Ellen Englert
4160 Patterson Ave
Baltimore, MD 21215

Dear Ellen,

Doctors Community Hospital is writing this letter to request the continuation of its ability to tier its clinic rate, specifically for our Cardiac Rehab and Pulmonary Rehab services. Pulmonary Rehab is a new service that was added in November 2011. Attached you will find departmental detail of direct expense per unit reported on the FY 2011 Annual Filing for the Clinic rate center. You will notice that there are significant variances in the expense between our four departments which make up the clinic rate center. It is for this reason that we request the ability to appropriately tier our clinic rate. We expect to tier this rate in a manner where the average rate charged will be in compliance with the overall approved clinic rate on our FY 2012 rate order.

Thank you for your time and consideration in this matter. Please feel free to contact me if you need any additional information or clarification.

Thank you,

Camille Bash
Director of Finance

APPENDIX - MEMORANDUMS

September 13, 2012

Camille Bash
Director of Finance
Doctors Community Hospital
8118 Good Luck Road
Lanham, Maryland 20706-3596

Dear Ms. Bash:

I am writing in response to your request to tier the Clinic facility fees at Doctors Community Hospital based on relative cost. Your request has been approved effective July 1, 2012.

The Hospital will be notified of any additional reporting requirements associated with the approved tiering. While it is anticipated that tiering of clinics and emergency department rates will be permitted beyond FY 2013, you will be notified as to whether the approval to tier extends beyond FY 2013.

If you have any questions concerning the above, you may contact me at 410-764-2565.

Sincerely,

Dennis N. Phelps
Associate Director,
Audit & Compliance

APPENDIX - MEMORANDUMS

MedStar Health

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

August 21, 2012

Mr. Dennis Phelps
Associate Director, Audit and Compliance
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Dennis,

We would like to request permission to tier MedStar Franklin Square Medical Center's clinic rates effective July 1, 2012. Our analysis supporting this request was previously provided to your office.

If you have any questions, please do not hesitate to contact me at (410) 933-2375.

Sincerely,

Kathy Talbot

Kathy Talbot
Vice President
Rates & Reimbursement
MedStar Health, Inc.

APPENDIX - MEMORANDUMS

August 27, 2012

Kathy Talbot
Vice President
Rates & Reimbursement
MedStar Health, Inc.
80010 Suite O Corporate Drive
Nottingham, Maryland 21236

Dear Ms. Talbot:

I am writing in response to your request to tier the Clinic Department facility fees at Franklin Square Medical Center based on relative cost. Your request has been approved effective July 1, 2012.

The Hospital will be notified of any additional reporting requirements associated with the approved tiering. While it is anticipated that tiering of clinics and emergency department rates will be permitted beyond FY 2013, you will be notified as to whether the approval to tier extends beyond FY 2013.

If you have any questions concerning the above, you may contact me at 410-764-2565.

Sincerely,

Dennis N. Phelps
Associate Director,
Audit & Compliance

APPENDIX - MEMORANDUMS

July 13. 2012

Ed Beranek
Director of Regulatory Compliance
Johns Hopkins Health System
Johns Hopkins at Keswick
3910 Keswick Road
Baltimore. Maryland 21211

Dear Mr. Beranek:

I am writing in response to your request to tier the Clinic and Emergency Department facility fees at Johns Hopkins Hospital. as well as the Clinic Department facility fees at Johns Hopkins Bayview Medical Center based on relative cost. Your request has been approved effective July 1. 2012.

The Hospitals will be notified of any additional reporting requirements associated with the approved tiering. While it is anticipated that tiering of clinics and emergency department rates will be permitted beyond FY 2013. you will be notified as to whether the approval to tier extends beyond FY 2013.

If you have any questions concerning the above. you may contact me at 410-764-2565.

Sincerely.

Dennis N. Phelps
Associate Director.
Audit & Compliance