THE ALTERNATIVE RATE SETTING METHODS ("ARM") MANUAL 1998

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.01 PURPOSE AND AUTHORITY

The purpose of the Alternative Rate Setting Manual ("Manual") is to provide a comprehensive description of the Alternative Rate Setting Methods ("ARM") System. The Health Services Cost Review Commission ("HSCRC" or "Commission") is authorized by law to promote and approve alternative methods of rate determination and payment that are of an experimental nature in order "[t]o promote the most efficient and effective use of health care facility services, if it is in the public interest and consistent with the subtitle." (Health-General Article, §19-216(c)) The Commission is further authorized to accept, evaluate, and act on applications for alternative methods of rate determination in accordance with its regulations under COMAR 10.37.10.06.

.02 MANUAL FORMAT AND REVISIONS

The Manual contains two sections: Section 100 provides an overview of ARM and sets forth in detail the review and approval process, rate-setting implications, application submission requirements for each category of ARM discussed, monitoring and compliance requirements, and penalties for non-compliance. Section 200 describes the reporting requirements and provides detailed instructions for the Schedules to be completed. Updates to the Manual will be issued by the staff from time to time.

.03 OVERVIEW OF ARM

Alternative Rate Setting comprises the Commission's efforts to encourage innovative and cost-saving payment arrangements without compromising the Commission's long-standing principles of equity and access. To preserve equity a hospital must be paid Commission approved unit rates and may not directly take financial risks. However, it may take risks through a related entity.

Any hospital or related entity that seeks to contract for payment at other than Commission approved rates must receive Commission approval, especially if the arrangement involves financial risks. Capitation contracts, global, or case rate pricing or other forms of fixed price contracting are examples of financial risks for which prior approval must be obtained.

Other types of alternative rate arrangements such as procedure-based pricing, must also receive Commission approval even though they do not involve financial risks. Procedure-based pricing bundles a set of unit rates associated with a procedure and may be affected directly by the hospital. A new rate for the bundled procedure is established on the hospital's rate order. There is no risk on these arrangements since they are based on hospital's historical costs and are subsequently rate re-aligned. And since they are Commission approved rates, the hospital is always paid

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Commission rates. These arrangements only permit hospitals to charge a fixed average combined rate for particular cases or procedures.

If a hospital or a related entity is unsure as to whether a particular contract or arrangement requires Commission approval, an inquiry should be made to the Commission. *Hospitals failing to obtain Commission approval prior to establishing alternative rate arrangements with a payer--either directly or through a related entity--will be subject to significant monetary penalties. There may also be implications for future inflation adjustments and the Guaranteed Inpatient Revenue (GIR) System for non-compliant hospitals.* (See COMAR 10.37.10.06 and 10.37.12 and Section .14 below for penalties related to failure to comply with alternative rate setting requirements.)

.04 DEFINITION OF RELATED ENTITY

As per COMAR 10.37.12.01, a related entity is any entity that enters into at-risk arrangements for hospital services and which is either subject to the exercise of control or significant influence by the management or operating policies of a hospital or exercises control over the management or operating policies of a hospital. In either event, one of the entities is, or may be, prevented from fully pursuing its own separate interests by virtue of its relationship with the other entity. Two entities, both of which are related to a common entity, may also be considered related entities.

.05 WHEN TO FILE APPLICATION

Two issues determine the need for an alternative rate setting application: Does the arrangement involve payment for regulated hospital services at other than unit rates, and does a hospital assume all or some financial risk, either directly or indirectly? Financial risk includes, but is not limited to, fixed-price contracts, case rates, global prices, and capitation. If a hospital or a related entity is unsure whether a particular contract or arrangement requires Commission approval, an inquiry should be made to the Commission staff, who can judge whether or not a full application is required.

A hospital or its related entity seeking to enter into a contract to provide hospital services at other than unit rates must apply to the Commission at least 30 days in advance of the commencement date of the contract with the payer. In all cases, prior Commission approval is required.

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.06 APPLICATION REQUIREMENTS

Applications shall consist of a public rate application to be filed with the Commission and distributed to each of the Commissioners and the members of the Commission's list of Designated Interested Parties; and a separate supplement containing the confidential information relevant to the type of alternative rate being requested. The public application consists of a complete and clear outline of the proposed arrangement, which lists: (1) the services to be provided under the rate; (2) how payment for services are distributed among the parties to the contract; (3) the length and effective date of the proposed contract; (4) the names of the hospital(s), related entities, and the insurer or third-party payer involved in the contract; (5) the level and nature of the risk for the hospital; and (6) the steps taken to limit the hospital's risk that the rate will not be sufficient to fund the costs of services at HSCRC rates (including the plans expected to restrain utilization under a fixed price contract). A separate application shall be submitted for each insurer or third-party payer, and for each book of business (Commercial, Medicare, or Medicaid) with that payer. The requirement for separate applications is intended to expedite Commission consideration of applications that readily meet Commission standards for approval, while applications that do not meet those standards may be revised and resubmitted until those standards are met, or the Commission acts to disapprove them. The Commission may require submission of, or access to, a draft copy of the proposed contract with the payer. Contracts that allow for the provision of hospital services should contain provisions: a) that clarify the requirement of prior Commission approval; b) that HSCRC approved rates must be paid until the contract is approved; and c) that the Commission may call for termination of the contract at its discretion. Applications fall into one of six general categories: (1) Procedure-based Pricing for ambulatory surgery; (2) Global Pricing or Case Rates for selected inpatient procedures; (3) Partial Capitation; (4) Full Capitation; (5) Notifications for Extension of Previously Approved Applications; and (6) Simplified Procedures for the Renewal of Commission approval of ARM arrangements that are due to expire. The application requirements for each category are described in sub-sections .06 A to .06 F below. Appendix 100 summarizes the submission requirements for all types of applications.

A. Procedure-based Pricing

Procedure-based pricing is the bundling of the component hospital unit rates for a medical procedure, establishing a new unit rate for the procedure in question.

For procedure-based pricing, the hospital should submit three items to demonstrate that the proposed price is cost-justified:

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a) A cost study showing the methodology and calculations used to determine the ancillary cost allocations to the procedure or case-based revenue center;
b) Machine-readable versions of data used to compute weighting of the cases or procedures; and
c) Calculations used to develop procedure based revenue center and rate (which may include banking of revenue).

See Appendix 100 for a template of an application for procedure-based pricing.

B. Global or Case-Rate Pricing

Case rate pricing is the bundling of the hospital's unit rates associated with the course of treatment for a particular patient visit or inpatient stay, often defined at the level of a DRG or a major ICD-9 group. Hence, the units of service encompassed under the case rate are broader than under procedure-based pricing.

Global pricing encompasses not only the hospital rates associated with a case but also the professional services provided during the course of treatment, usually negotiated between a hospital and a physician group as a joint venture.

For global or case-rate pricing, the hospital must provide evidence that the components of the price are reasonable with respect to the underlying historical costs. For global pricing of inpatient services, both the professional and the facility portion of the care must be reasonably related to historical costs. This assures that the risk-taking related entity is not generating an undue discount or subsidy for payers. If the hospital desires to offer a price lower than historical costs would justify, the hospital must provide evidence of a plan for increasing efficiency. The hospital should submit:

a) The cost calculations used to derive the global price;
b) Date used to compute prices;
c) An accounting of the deviations between historical and contracted prices; and
d) A clinical or financial justification for deviations between the proposed prices and historical costs (which may include documentation of the availability of non-regulated services at certain prices).

Appendix 100 includes a template of an application for global or case-base pricing.

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C. Partial Capitation

For partial capitation (contracts involving minimal risk through limited risk corridors or utilization incentive pools for regulated hospital services), hospitals must submit data documenting the extent of the financial risk for the hospital or the related entity and show how the capitation rate is distributed across the various components of the contract. The Commission will consider arrangements to be partial capitation if the hospital or a related entity accepts a negligible amount of downside risk from Commission approved rates. See Appendix 100 for a template of a capitation application.

D. Full Capitation

For full capitation (contracts involving significant risk for a broad range of services, including regulated hospital services), hospitals must submit a signed letter from a responsible officer designating an independent actuary to evaluate the proposed contract, a signed statement of actuarial opinion from that actuary attesting to his or her conclusions and an actuarial memorandum justifying that proposed capitation rates are sufficient to fund all covered services, including regulated hospital services at unit rates. These requirements provide the Commission with some assurance that approved rates will be paid and that the contract is not a vehicle for providing discounts. Contracts with third party payers should be written to require payment at unit rates until Commission approval is obtained.

See Appendix 100 for what is required in an actuarial memorandum and certification and for a template of a capitation application.

E. Extension of Previously Approved Applications

Each alternative rate contract with a payer must be submitted for Commission approval. However, the Commission has delegated to staff the authority to approve contracts that are identical or substantially the same as contracts already approved by the Commission. In these cases, the application may consist of simply a letter of notification certifying that the terms are substantially the same as a previously approved contract, and specifying any terms that may have changed. The application letter and a certificate of service must be forwarded to each Commissioner and all Designated Interested Parties. Supporting documentation identifying the payer should be provided to staff. This information will be kept confidential.

If the staff determines that the proposed extension is not substantially the same as previously approved, the hospital must submit a full application.

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Instructions:

To apply to the Commission for approval of an application for an alternative method of rate determination where the contract being offered is the same or substantially the same as a previously approved arrangement, the hospital should notify the Commission and Designated Interested Parties by certified letter. In the letter the hospital should:

- Identify the previously approved arrangement (by HSCRC proceeding number).
- Provide a statement affirming the fact that the contract is either the same or substantially the same as the previously approved arrangement.
- If the contract is not identical but substantially the same, include a description of the differences between the approved arrangement and the arrangement in question.
- Close the letter with a signature from the CFO of the hospital.

F. Renewal of Approval of Substantially Similar Contracts

Commission approval of alternative rate applications is granted for a fixed time period of no more than three years, although the Commission may approve contracts for a shorter period if it has concerns about the performance of the Hospital under the contract. Before the period of approval expires (but at least thirty days in advance), if the Hospital is in compliance with all reporting requirements of the Commission with regard to the alternative rate approval, and the Hospital expects no substantial changes in the contract, the Hospital may submit a simplified renewal application.

The renewal application shall consist of a public disclosure of the proposed contract, as described earlier in this section, to be docketed as a new Commission proceeding. In addition, the Hospital should submit confidentially a projected budget for the period for which extended approval is requested, summarizing the covered lives, expected revenues, and expenditures for institutional and noninstitutional services. The Hospital should also submit a summary highlighting any changes proposed to the terms of the contract that had been previously approved, such as changes in payment rates, covered services, arrangements for stop-loss insurance, if any, changes to the risk pooling or incentive payments, and so on. The Hospital CFO should enclose a letter certifying his or her

understanding of the proposed arrangements, the requirements for financial soundness, and the other requirements for Commission approval. Staff may also request a copy of the proposed contract to confirm these details.

Staff will review the submitted data to determine if the contract is substantially the same as what had been previously approved, if the reports filed with the Commission show that the contract experience has been financially sound, and if the financial feasibility of the contract can be expected to continue. Staff will then determine whether to recommend a renewed approval to the Commissioners. If the data do not support the favorable experience or the terms of the contract are changed substantially, the Hospital may be required to submit a full application, including independent actuarial review of capitation arrangements.

G. Memorandum of Understanding

If approved by the Commission, all alternative rate applications will require the execution of a Memorandum of Understanding (MOU) between the hospital and the Commission memorializing each party's understanding of the terms of the alternative rate approval, including provisions for confidentiality of data, reporting requirements, and project termination or modification provisions. A template MOU is provided in Appendix 100.

Failure to fully and correctly flag cases under alternative rate arrangements in the Hospital Discharge Data Set will be considered a failure to correctly file these data and potentially subject hospitals to fines.

.07 CONFIDENTIALITY

The Commission maintains the confidentiality of all data submitted with alternative rate applications, consistent with applicable law and regulation. A public application for an alternative rate arrangement must be submitted to the Commission offices, along with a certificate of service that copies of the application have been provided to the Commissioners and to the Commission's list of designated interested parties. The public application should describe the proposed arrangement in general terms, including commencement and termination dates, and the applicant's arguments for how the proposed rate arrangement will meet the Commission's criteria for approval. Along with the public application that will be docketed as a Commission proceeding and appear on the public record, the applicant should, at the same time, supply the Commission staff with all of the supporting documentation relevant to the type of alternative rate application. This supporting information may be designated to be treated as confidential proprietary information by Commission staff.

Thus, for example, actuarial memoranda, statements of actuarial opinion, utilization assumptions and fee schedules for unregulated services, as well as, the name of the payer may properly be considered confidential commercial information and, as such, will not be publicly disclosed. Similarly, capitation rates will be considered confidential because they are population specific; they cover a wide range of services, many of which are not regulated; and their public release does not allow for a fair comparison of rates to be made.

At the same time, however, the all-payer nature of the rate setting system must be preserved. Procedure-based rates will be disclosed in publicly available rate orders. A hospital that receives Commission approval for global price arrangements agrees to make the approved price available to all payers (provided that the characteristics of the new payer's population do not deviate from the assumptions the hospital used to develop the original global price.) In order to ensure that this requirement is met, the Commission reserves the right to facilitate the ability of payers to compare hospital global prices.

The Commission encourages hospitals and their related entities to facilitate access to this information on their own, obviating the need for the Commission to devise a reporting method that may not optimally present a particular hospital's product.

.08 APPROVAL CRITERIA

In reviewing alternative rate applications, the Commission looks to uphold its mandates for equity, access, solvency, and cost containment. If the submitted data demonstrate that payments under the contract are commensurate with expected costs, the Commission will have some assurance that the contract does not provide a preferential discount. Equity must also be maintained by making alternative pricing arrangements available to all payers on the same terms and conditions. (Capitation arrangements may vary based on the characteristics of the population). Finally, the Commission must be assured that the arrangement will not deny or limit access to hospital services for any Marylanders.

Full Commission approval is required only for the first contract of each type (global, partial capitation, full capitation) for each class of payer (Medicare, Medicaid, commercial). Once the Commission has approved a managed care arrangement for any class of payer, a hospital may offer the same or substantially the same contract to any payer within that class. In these cases, although the Commission requires an application, the application may consist of simply a letter of notification identifying the new payer, certifying that the terms are substantially the same as a previously approved contract, and specifying any terms that may have changed. See Section .06 E. The

application letter and a certificate of service must be forwarded to each Commissioner and all Designated Interested Parties. See Appendix 100 for a description of this type of notification.

.09 TIMING FOR APPROVAL

Though approval times will vary based on the number of applications submitted in any given month, a complete application for global contracts received by the first of a month can usually be considered at the Commission meeting the following month. Capitation contracts may take longer to review depending on the complexity of the arrangement and the quality of the data submitted, and should be submitted well in advance of the expected contract date. Commission regulations require that all applications be submitted at least 30 days before the proposed effective date of the contract. COMAR 10.37.10.06E(5) Hospitals should work with Commission staff to ensure that their applications are *complete* and *consistent* with Commission application requirements to ensure timely review and approval.

.10 GIR AND TPR IMPLICATIONS

Hospitals have the potential to receive double rewards through the Guaranteed Inpatient Revenue (GIR) System and certain alternative rate arrangements. In these instances, the Commission will work with the hospital to determine the appropriate GIR adjustments to ensure that such double rewards are not provided. Hospitals will be required to flag cases under alternative rate arrangements so they can be treated appropriately under the GIR. Hospitals are also required to factor in expected rate increases from the IAS when calculating alternative rate structures. Special arrangements will also be negotiated with Total Patient Revenue (TPR) System hospitals to prevent double payment.

.11 REPORTING REQUIREMENTS

Hospitals receiving approval for alternative rate applications are required to submit certain reports to allow the Commission to monitor compliance with the terms of the approval. (COMAR 10.37.10.06E) For capitation arrangements, quarterly and annual reports on income and expenses and utilization are required (See Schedules AR-1 and AR-2 in Section 200) For global price arrangements, a global price revenue report (Schedule AR-3) must be filed quarterly and annually. In addition, an audited financial statement of the contracting related entity as well as Special Audit Procedures to verify the accuracy of the annual AR-1, AR-2, or AR-3 reports are required. Hospitals with approval for procedure or case-based pricing must also submit quarterly reconciliation schedules until revenue neutrality with fee for service rates is assured. Procedure or case-based revenue centers and rates are treated as other centers and rates with the exception that a supplemental

schedule must be filed annually which discloses the costs and statistics of the individual revenue centers from which the procedure or case-based center was created.

If a hospital has Commission approval for a managed care contract but finds itself in the position of not having an active contract, the hospital is required to notify the Commission of this fact by filing a blank report with the notation "No Contract Executed" on the same schedule as that required for active contracts. If the hospital believes that no contract will be executed under the terms of an alternative rate proceeding, the hospital may notify the Commission staff, who have been delegated the power to rescind Commission approval and relieve the hospitals of reporting requirements for that rate proceeding.

.12 MONITORING FOR COMPLIANCE

Monitoring compliance with alternative rate regulations

At all times, the Commission retains the authority to terminate or require the renegotiation of any contract which it believes provides an inappropriate discount for any payer or class of payers. The Commission will rely, in part, on the renewal process to enforce compliance. Commission approval of managed care contracts generally lasts for three years. After three years, the Commission may require hospitals to certify again that the expected costs going forward are reasonably related to the income under the contract based on data from actual experience under the contract.

Hospital funding of the legitimate start-up or other capital costs of the contracting entity is not considered a preferential discount, but is allowable under the Commission's policy of permitting hospital management to invest surpluses from operations. At the same time, however, *the Commission will not allow operating losses from alternative payment arrangements to be compensated in hospital's fee for service rates,* as this would create an unfair subsidy from fee for service payers to managed care payers.

.13 PENALTIES

As set forth in COMAR 10.37.10.06 and 10.37.12, the Commission may impose penalties of up to $250 per day for failing to file required reports in a complete and timely manner. These reports appear in Section 200 of the Manual.

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Any required report submitted which is substantially incomplete or inaccurate will be considered untimely filed. The Commission may refuse to grant a rate increase to any hospital that is deficient in meeting its reporting requirements.

An application for an alternative rate application must be filed at least 30 days before the proposed effective date of the alternative rate. It is in the best interests of all applicants that applications be filed with the Commission as far in advance as possible before commencement of the contract in order that deficiencies can be corrected before the 30 day review period.

A fine assessed for failure to file an alternative rate application on a timely basis begins on the due date of the application, i.e., 30 days before the contract is to take effect.

Failure to fully and correctly flag cases under alternative rate arrangements in the hospital discharge abstract data set, as set forth in COMAR 10.37.06, will be considered a failure to correctly file these data and potentially subject a hospital to fines.

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SAMPLE APPLICATION - AMBULATORY SURGERY SERVICES

Introduction

This application for an alternative Method of Rate Determination (the "Application") is submitted by _____ ("the Hospital") pursuant to COMAR 10.37.10.06. The purpose of the application is to seek approval for an alternative method of charging for ambulatory surgery services performed at the Hospital. The Hospital will provide all information that the Health Services Cost Review Commission (the "Commission") or its staff deems necessary to evaluate and subsequently review for compliance with the alternative method of charging for ambulatory surgery services. This application seeks approval for participation for a minimum period of three years beginning _____.

Overview of Application

[Explanation of why the hospital is requesting approval for procedure or case-based pricing, e.g., changes in the health care market, competition with unregulated facilities, etc.]

Proposed Procedure or Case-Based Pricing

[Description of how new revenue center will be created, i.e., from which other center will revenue be allocated to form new center.]

[Rationale and methodology for allocation of revenue from each applicable center.]

[Description of how new procedure or case rates were developed based on historical data.]

In addition, in accordance with HSCRC regulation a Certificate of Service must be attached to the application.

SAMPLE APPLICATION- GLOBAL PRICING

The _____ Hospital ("Hospital") hereby files this application for an Alternative Method of Rate Determination pursuant to COMAR 10.37.10.06. The purpose of this application is to seek approval for an alternative method of charging for (name of service and/or DRG). The Hospital will provide all information that the Health Services Cost Review Commission (the "Commission") or its staff deems necessary to monitor the progress of the alternative method of charging for _____. This application seeks approval for participation for a minimum of three years beginning _____.

Application Overview

[Description of the service and/or program.]

[Description of the contracting entity and its relationship to the Hospital.]

[Reasons for the Hospital's involvement in the global price arrangement, e.g., competition, loss of volume, possible loss of teaching program, etc.]

[General description of how global fee is developed.]

[Assurance that Hospital will be paid HSCRC approved rates.]

[General discussion of risk sharing arrangements.]

[Explanation of how the proposed arrangement will preserve the HSCRC's principles of equity, access, and cost containment.]

In accordance with HSCRC regulation, a Certificate of Service must be attached to the application.

MOU TEMPLATE
GLOBAL PRICING

Memorandum of Understanding

Between

_____

and

The Health Services Cost Review Commission

The Health Services Cost Review Commission ("Commission") and _____ ("Hospital"), by their undersigned representatives, agree and memorialize their understanding with respect to the implementation of the Alternative Method of Rate Determination for a "global priced" agreement (the "Agreement") as stated below. In any case of conflict or ambiguity, the provisions of the Staff Recommendation in Proceeding # _____ as approved by the Commission shall govern.

1. The Hospital agrees that this Memorandum of Understanding supersedes all prior Memorandums of Understanding executed in association with global priced agreements and shall apply to proceedings _____. In addition, unless otherwise directed by the Commission, this MOU shall also apply to all future global priced alternative rate applications.

2. The Hospital agrees to the following reporting requirements associated with the Agreement.

   a. The Hospital shall notify the Commission in writing within 10 days from when a bid under the Agreement has been accepted by a payer.

   b. The Hospital shall identify the payer, the commencement date for the Agreement, and shall provide the Commission with a copy of the fully executed Agreement with all attachments including, if applicable, every specific rate by sex, age, or other category.

   c. The Hospital shall provide the Commission in a timely manner with access to all financial records associated with the contractual relationship between _____ and the Hospital as it relates to the provision of the Agreement.

   d. The Hospital shall provide the Commission, beginning three months after the effective date of a signed contract between _____ and a payer, with access on a quarterly basis to all of the financial records of _____ directly related to the Agreement.

   e. Subsequent to the effective date of the signed contract between _____ and a payer, the Hospital shall provide the Commission, within the time frame prescribed by Commission regulation, with reports of the financial experience and utilization associated with the Agreement in the manner prescribed in COMAR 10.37.10.06.

3. All materials submitted to the Commission relative to the Contract shall be treated as proprietary and confidential to the Hospital and shall not be released to third parties unless deemed by the Commission to be required by law or regulation. The Hospital shall be provided written notice by the Commission of any potential release of confidential information to third parties. The Hospital shall be entitled to contest the potential release of such information.

4. The Hospital agrees that hospital services as defined in Health-General Article §19-201, shall be reimbursed at 100% of the providing hospital's Commission approved rates, subject to the Commission's regulations regarding prompt payment and SAAC differential (COMAR 10.37.10.26) as well as the terms of the Medicare and Medicaid waiver agreement.

5. The Hospital agrees to offer contracts at the same price under these same terms to any additional payers that request them, provided that the new payers are willing to agree to the same terms required of the payers originally approved by the Commission. Should the Hospital and a potential payer disagree that the payer is entitled to the same price under the terms, the Hospital shall provide to the Commission staff within 30 days a written justification as to why the costs of serving a new payer would be different from that of the payer originally approved. The disputing payer shall have 30 days to respond to the Hospital's argument, and Commission staff shall then make a final determination.

6. Should the Hospital choose to offer additional payers a contract under the same or substantially similar terms approved under this application, the Hospital shall notify the Commission and Designated Interested Parties in a letter expressing its intent at least 30 days before entering into such an agreement. At the same time, the Hospital shall provide Commission staff with sufficient information to evaluate whether the proposed new agreement is substantially similar. If staff determines the new agreement is a significant change from the agreement approved under this application, the Hospital shall prepare a new application pursuant to COMAR 10.37.10.06.

7. Renewal of this agreement is guaranteed at the same price and terms for the entire period approved by the Commission in the Staff Recommendation. If the agreement between the Hospital and Payer involves a renegotiation or updating of the price or other contract terms, the Hospital agrees to submit the renewal agreement to the Commission staff to assure that the renegotiated price is in conformance with the underlying principles of this proposal. If staff determines the renewal agreement is a significant change from the agreement approved under this application, the Hospital shall prepare a new application pursuant to COMAR 10.37.10.06.

8. The Hospital agrees to "flag" the cases associated with the "global priced" agreements so that they may be identified in the Hospital Discharge Data Set. The cases shall be flagged by utilizing the designation assigned by the Commission (in accordance with COMAR 10.37.06) specific to this Agreement.

09. The Hospital agrees that all cases associated with this Arrangement shall be excluded from the Hospital's Guaranteed Inpatient Revenue System.

10. The Hospital agrees that losses associated with the Agreement shall not be recognized by the Commission as reasonable costs for reimbursement, nor shall such losses be considered justification for a rate increase.

11. The Hospital agrees that it will provide adequate notice of this Memorandum of Understanding, and the principles incorporated herein, to all those persons or entities directly or indirectly involved in the Agreement--e.g., HMOs, PPOs, physician, etc. In addition, the Hospital agrees to certify to the Commission within a reasonable time that it has provided a copy of this Memorandum of Understanding to any payer with whom it has entered into an agreement.

12. The Hospital agrees to comply with all current and future applicable Maryland statutory and regulatory requirements, including, but not limited to, those of: the Health Services Cost Review Commission, the Health Care Access and Cost Commission, the Health Resources Planning Commission, the Department of Health and Mental Hygiene, and the Insurance Administration.

13. The Hospital affirms that there are not now, nor will there be in the future, any transfer of funds, in-kind goods or services, or any other consideration associated with, or as a result of this Arrangement involving the Hospital, directly or indirectly, which has the effect of discounting the Commission approved rate. This provision, however, does not preclude investments in the related entity by the Hospital which are not intended to fund the provision of health care services. Such investments may

include recapitalizations for the purpose of replenishing or augmenting start-up costs, administrative and/or overhead costs or the initiation or expansion of other activities not related to this arrangement. A written description of such investments shall promptly be reported to the Commission. A violation of this provision may subject the Hospital to all penalties provided for in Commission regulation including, but not limited to:

a) fixed price contracting COMAR 10.37.12;

b) inaccurate reporting, COMAR 10.37.01 and 10.37.10;

c) price corridors, COMAR 10.37.03; and

d) the Hospital's GIR Agreement.

14. Either the staff of the Commission or the Hospital may desire to terminate the Agreement. In the event the Hospital requests termination of the Agreement, it may do so at its own discretion, and it shall provide the Commission with written notice of such request. If the staff desires to terminate the Agreement, it shall notify the Hospital immediately and then set forth in writing its reasons demonstrating cause for recommending termination. The staff shall forward its recommendation to the Hospital, which shall have 90 days from receipt of notice from the staff (the "cure period") to provide evidence of its efforts to cure the defects in the Agreement as alleged by the staff. If the staff determines at the end of the cure period that the defects have not been cured, it may recommend to the Health Services Cost Review Commission that the Agreement be terminated. If the staff believes that a cure period would be against the public interest, it may recommend an immediate termination of

the Agreement to the Commission. The staff shall have the burden of demonstrating to the Commission by a preponderance of the evidence that a cure period prior to termination of the Agreement is against the public interest.

The Commission, after receiving the staff recommendation that the Agreement be terminated, shall provided an opportunity for the staff and the Hospital to present evidence and argument for and against the staff recommendation. If, after hearing from both the staff and the Hospital, the Commission is satisfied that the Hospital has taken the necessary steps to justify continuation of the project, the Contract shall continue. If the Commission is not satisfied upon completion of the cure period that the steps taken warrant continuation of the Agreement, or if it has been convinced by the staff through a preponderance of the evidence that a cure period is against the public interest, then the Commission shall allow a reasonable period of time to effectuate a smooth and final termination of the Agreement, taking into account, among other things, the Hospital's contractual obligations. In any event, the Commission, shall be the final arbiter on termination of the Agreement, and any decision by the Commission to terminate shall be final and non-appealable. The Hospital shall have the right to file a new application with the Commission pursuant to COMAR 10.37.10.06.

Date:_____

_____
Robert Murray, Executive Director
Health Services Cost Review Commission

Date:_____

_____
Hospital Authorized Representative

SAMPLE APPLICATION -CAPITATION ARRANGEMENTS

(Application for both full and partial are virtually the same)

INTRODUCTION

_____ (the "Hospital") hereby files this application for an Alternative Method of Rate Determination (the "Application") pursuant to COMAR 10.37.10.06. The purpose of the Application is to seek approval for affiliated entities to enter into capitated managed care contracts (the "Project") for professional and outpatient services. The Application seeks approval for participation in the Project for a minimum of three years beginning _____. The Hospital and the related entity will provide all information that the Health Services Cost Review Commission (the "Commission") or its staff deems necessary to monitor the progress of the Project.

Application Overview

[Description of the contracting entity and its relationship to the Hospital.]

[Clear and concise description of the contract including:

- Function of the related entity in the arrangement, i.e., to enter into contract as well as to manage costs by managing utilization and by entering into cost effective arrangements with other providers.

- Summary of the services to be provided by the related entity under the arrangement and by whom they are to be provided, e.g., physician services, by physician employed by related entity, outpatient services to be provided by the Hospital or the most cost efficient provider, etc.

- Who is responsible to pay for inpatient hospital services

MOU TEMPLATE
CAPITATION

Memorandum of Understanding

Between

_____

and

The Health Services Cost Review Commission

The Health Services Cost Review Commission ("Commission") and _____ ("Hospital"), by their undersigned representatives, agree and memorialize their understanding with respect to the implementation of the Alternative Method of Rate Determination for a "capitation" arrangement (the "Arrangement") as stated below. In any case of conflict or ambiguity, the provisions of the Staff Recommendation in Proceeding # _____ as approved by the Commission shall govern.

1. The Hospital agrees that this Memorandum of Understanding ("MOU") supersedes all prior Memorandums of Understanding executed in association with capitation arrangements and shall apply to proceedings _____. In addition, unless otherwise directed by the Commission, this MOU shall also apply to all future capitation alternative rate applications.

2. The Hospital agrees to the following reporting requirements associated with the Arrangement.

a. The Hospital shall disclose the commencement date for the Arrangement and shall provide the Commission with a copy of the fully executed Arrangement with all attachments including, if applicable, every specific rate by sex, age, or other category.

b. Subsequent to the effective date of the signed contract between _____ _____ and a payer, the Hospital shall provide the Commission, in the time frame prescribed by Commission regulation, with annual and quarterly reports to include but not be limited to those reports prescribed in COMAR 10.3710.06(E).

c. The Hospital shall provide the Commission in a timely manner with access to all financial records associated with the contractual relationship between _____ and the Hospital as it relates to the provision of the Arrangement.

3. All materials submitted to the Commission relative to the Arrangement shall be treated as proprietary and confidential to the Hospital and shall not be released to third parties unless deemed by the Commission to be required by law or regulation. The Commission shall provide the Hospital with written notice of any request for release of confidential information to third parties. The Hospital shall be entitled to contest the requested release of such information.

4. The Commission agrees that an expedited approval process may be utilized:

a. when a previously approved capitation arrangement is to be materially updated or expanded; or

b. when minor modifications to an existing capitation arrangement are to be made.

An expedited approval process is described in the Alternative Rate Setting Manual.

5. The Hospital agrees to "flag" the cases associated with this Arrangement so that they may be identified in the Hospital Discharge Data Set. The cases shall be flagged by utilizing the designation assigned by the Commission (in accordance with COMAR 10.37.06) specific to the Arrangement.

6. The Hospital agrees that all cases associated with this Arrangement shall be excluded from the Hospital's Guaranteed Inpatient Revenue System.

7. The Hospital agrees that losses associated with the Arrangement shall not be recognized by the Commission as reasonable costs for reimbursement, nor shall such losses be considered justification for a rate increase.

8. The Hospital agrees that it will provide adequate notice of the Memorandum of Understanding, and the principles incorporated herein, to all those persons or entities directly or indirectly involved in the Arrangement -- e.g., HMOs, PPOs, physicians, etc. In addition, the Hospital agrees to certify to the Commission within a reasonable time that it has provided a copy of this Memorandum of Understanding to any payer with whom it has entered into an arrangement.

9. The Hospital agrees to comply with all current and future applicable Maryland statutory and regulatory requirements, including, but not limited to, those of: the Health Services Cost Review Commission, the Health Care Access and Cost Commission, the Health Resources Planning Commission, the Department of Health and Mental Hygiene, and the Insurance Administration.

10. The Hospital agrees that hospital services, as defined in Health-General Article §19-201, shall be reimbursed at 100% of the providing hospital's Commission approved rates, subject to the Commission's regulations regarding prompt payment and the SAAC differential (COMAR 10.37.10.26) as well as the terms of the Medicare and Medicaid waiver agreement.

The Hospital also affirms that there are not now, nor will there be in the future, any transfer of funds, in-kind goods or services, or any other consideration associated with, or as a result of this Arrangement involving the Hospital, directly or indirectly, which has the effect of discounting the Commission approved rate. This provision, however, does not preclude investments in the related entity by the Hospital that are not intended to fund the provision of health care services. Such investments may include recapitalizations for the purpose of replenishing or augmenting start-up costs, administrative and/or overhead costs, or the initiation or expansion of other activities not related to this arrangement. A written description of such investments shall promptly be reported to the Commission. A violation of this provision may subject the Hospital to all penalties provided for in Commission regulation including, but not limited to:

a) fixed price contracting COMAR 10.37.12;

b) inaccurate reporting, COMAR 10.37.01 and 10.37.10;

c) price corridors, COMAR 10.37.03; and

d) the Hospital's GIR Agreement.

11. Either the staff of the HSCRC or the Hospital may desire to terminate the Arrangement. In the event the Hospital requests termination of the Arrangement, it may do so at its own discretion, and shall provide the Commission with written notice of such request. If the staff desires to terminate the Arrangement, it shall notify the Hospital immediately and then set forth in writing its reasons demonstrating cause for recommending termination. The staff shall forward its recommendation to the Hospital, which shall have 90 days from receipt of notice from the staff (the "cure period") to provide evidence of its efforts to cure the defects in the Arrangement as alleged by the staff. If the staff determines at the end of the cure period that the defects have not been cured, it may recommend to the HSCRC that the Arrangement be terminated.

If the staff believes that a cure period would be against the public interest, it may recommend an immediate termination of the Arrangement to the Commission. The staff shall have the burden of demonstrating to the Commission by a preponderance of the evidence that a cure period prior to termination of the Arrangement is against the public interest.

The Commission, after receiving the staff recommendation that the Arrangement be terminated, shall provide an opportunity for the staff and the Hospital to present

evidence and argument for and against the staff recommendation. If, after hearing from both the staff and the Hospital, the Commission is satisfied that the Hospital has taken the necessary steps to justify continuation of the Project, the Arrangement shall continue. If the Commission is not satisfied upon completion of the cure period that the steps taken warrant continuation of the Arrangement, or if it has been convinced by the staff by a preponderance of the evidence that a cure period is against the public interest, then the Commission shall allow a reasonable period of time to effectuate a smooth and final termination of the Arrangement, taking into account, among other things, the Hospital's contractual obligations. In any event, the Commission shall be the final arbiter on termination of the Arrangement, and any decision by the Commission to terminate shall be final and non-appealable. The Hospital shall have the right to file a new application with the Commission pursuant to COMAR 10.37.10.06.

Date:_____

_____
Robert Murray, Executive Director
Health Services Cost Review Commission

Date:_____

_____
Hospital Authorized Representative

Actuarial Opinion

The statement of actuarial opinion and accompanying actuarial memoranda will be a central element of the ex ante review process. The statement of actuarial opinion should consist of:[1]

- An ***opening paragraph*** identifying the appointed actuary and the actuary's qualifications.
- A ***scope paragraph*** identifying the subjects on which an opinion is to be expressed and describing the scope of the appointed actuary's work.
- A ***reliance paragraph*** describing those areas, if any, where the appointed actuary has deferred to other experts in developing data, procedures, or assumptions, supported by a statement of each expert.
- An ***opinion paragraph*** expressing the appointed actuary's opinion with respect to the reasonableness of the reserves and related actuarial items and the adequacy of the capitation rates.
- Additional paragraphs are required if the actuary considers it necessary to qualify the actuary's opinion or if data from other persons were relied upon in rendering an opinion.

The following language, or language substantially similar, shall be used in the statement of actuarial opinion. The required language is that, which in typical circumstances, should be included in a statement of actuarial opinion. The required language may be modified as needed to meet the circumstances of a particular case, but the appointed actuary should use language that clearly expresses the actuary's professional judgment and which indicates why the required language was not used.

Opening paragraph

The opening paragraph shall generally indicate in the following manner the appointed actuary's relationship to the risk-bearing entity and the actuary's qualifications to sign the opinion:

"I, *[name and title of actuary]*, am a member of the American Academy of Actuaries and am associated with the firm of *[name of consulting firm]*. I have been appointed by, or by

[1]Some of the components of the actuarial opinion deal with reserves while other components deal with the adequacy of capitation rates.

the authority of , the Board of Directors of [name of risk-bearing entity] to render this opinion as stated in the letter to the Health Services Cost Review Commission dated *[insert date]*. I meet the Academy qualification standards for rendering the opinion, including continuing education credits regarding Managed-Care Health Plans and general health care issues related to such plans."

An appointment letter should accompany the opinion.

Scope paragraph

The scope paragraph shall include a statement identical or similar to the following:

"I have examined the actuarial assumptions and actuarial methods used in determining the capitation rates to be charged as listed below and as filed with the Health Services Cost Review Commission in an application for an alternative method of rate determination."

and/or

"I have examined the actuarial assumptions and actuarial methods used in determining reserves and related actuarial items listed below, as shown in the annual statement of the Risk-bearing entity, as prepared for filing with the Health Services Cost Review Commission, as of December 31, 19[ ]."

Reliance paragraph

If the appointed actuary has relied on other experts to develop certain portions of the analysis, the reliance paragraph shall include a statement such as the following:

"I have relied upon *[name and title]* for substantial accuracy of the information concerning *[ ]*, as certified in the attached statement,...."

and/or

"I have relied on personnel as cited in the supporting memorandum for certain critical aspects of the analysis."

If the appointed actuary **has examined** the underlying records, the reliance paragraph shall also include the following:

> "My examination included such review of the actuarial assumptions and actuarial methods and of the underlying basic records and such tests of the actuarial calculations as I considered necessary."

If the appointed actuary **has not examined** the underlying records, but has relied upon listings and summaries of records prepared by the risk-bearing entity or a third party, or both, the reliance paragraph shall include a sentence identical to or similar to one of the following:

> "I have relied on listings and summaries prepared by *[name and title of company officer certifying listings and summaries]* as certified in the attached statement (see accompanying affidavit by an entity officer). In other respects, my examination included such review of the actuarial assumptions and actuarial methods and such tests of actuarial calculations as I considered necessary."

and/or

> "I have relied on *[name of accounting firm]* for the substantial accuracy of records listed below, as certified in the attached statement. In other respects, my examination included such review of the actuarial assumptions and actuarial methods and such tests of actuarial calculations as I considered necessary."

Such statements of reliance should be accompanied by a statement from each such expert as needed.

Opinion Paragraph

The opinion paragraph shall include the following:

> "In my opinion the [*capitation rates, reserves and related actuarial values]* identified above:
>
> (a) Are computed in accordance with those presently accepted actuarial standards which specifically relate to the opinion.
>
> (b) Are based on actuarial assumptions which produce *[rates which are adequate and reasonable in relation to the benefits provided/ reserves which are adequate to meet the outstanding obligations of the risk-bearing entity in accordance with all contract provisions]*;
>
> © Are computed on the basis of assumptions consistent with those used in computing the

corresponding items previously provided to the Commission by the risk-bearing entity (with any exceptions listed below);

(d) Include provision for all *[costs which could be reasonably foreseen, reserves and related items which should be established]*.

The actuarial methods, considerations and analyses used in forming my opinion conform to the appropriate Compliance Guidelines as promulgated by the Actuarial Standards Board, which guidelines form the basis of this statement of opinion.

For reserves, the following shall be included:

"To the best of my knowledge, there have been no material changes from the applicable date of the annual statement to the date of the rendering of this opinion which should be considered in reviewing this opinion."

or

"The following material change(s) which occurred between the date of the statement for which this opinion is applicable and the date of the opinion should be considered in reviewing this opinion: *(Describe the change or changes.)*"

The opinion should conclude with language identical or similar to:

"The impact of unanticipated events subsequent to the date of this opinion is beyond the scope of this opinion. The risk-bearing entity's future experience may not follow all the assumptions used in the analysis."

_____

Signature of Appointed Actuary

_____

Address of Appointed Actuary

_____

Telephone Number of Appointed Actuary

Actuarial Memoranda (AM)

The statement of opinion should be accompanied by an actuarial memorandum supporting the opinion and providing sufficient detail so that an independent actuary can form an opinion as to the reasonableness of the methods, considerations and assumptions used. The AM should demonstrate that the expected capitation rates are projected to be adequate during the term of the application.

The staff does not desire a separate AM for each contract. Contracts with similar benefit plans, capitation rates, target populations and risk sharing arrangements should be grouped together (except that Medicare, Medicaid and commercial contracts cannot be grouped together.) The AM should list the contracts that are being combined and indicate briefly how each one deviates from the general description applicable to the group of contracts being evaluated.

The AM should stand on its own. In particular:

- The AM should be accompanied by a copy of the application, the contract, the required certifications, and the appointment letter.

- The AM may refer to other documents, but any information from those documents which is needed should be restated, quoted or attached to the AM. This includes, but is not limited to, a description of the plan of benefits, contract, target population and any risk sharing arrangements as well as assumptions and actual experience regarding utilization, unit costs, and expenses. (The amount and number of restatements, quotes, and attachments should be kept to a minimum.)

- The AM should be consistent with the application and the contract. In particular the AM should cover the complete time period covered by the application. The organization(s) involved should be clearly identified and their roles and relationships clearly delineated.

- The AM should describe the benefit plan and specify all benefits which are carved out.

- The AM should clearly distinguish between base line data and assumptions and indicate the source of each.

- The AM should include separate analyses by non-overlapping time periods which are no longer than a year. Full (calendar) years are preferable. The combined time periods should contain the full term of the application.

- The AM should include information placing the application into context. This should include expected member months, revenue, inpatient days and outpatient visits under the application, and their relationships to the corresponding amounts expected for the all contracts and corresponding amounts for the hospital in total. These data should be developed using enrollment projections

covered by the application over the application period and a projection of the enrollment under all such capitated plans.

oThe AM should describe any reinsurance or stop-loss provided by the contractor or to be purchased commercially. The financial impact of such reinsurance should be provided.

oIf the capitation rate will vary by demographic or other parameters the AM should include the actuary's assumptions as to the distribution of those parameters, the source of those assumptions, and the development of he expected capitation rate based on those assumptions. For some parameters, such as copayments, the AM could demonstrate directly that a specific rate differential is justified.

oAdministrative expenses should be justified in relation to the projected total budget and the projected enrollment. (It is not required or expected that a project will have enough enrollment to break even during the first year or two).

oIf some services are subcapitated, for example primary care services, the AM should describe how the actuary arrived at the subcapitation used in the projection. In particular, has the actuary been shown the capitation rates for a reasonable fraction of the expected number of provider contracts?

oThe AM should contain reasonable justifications for all significant utilization and cost assumptions, especially the number of inpatient days per thousand.

oThe expected cost per inpatient day should be shown to be consistent with the most recent "Current Effective Rates" and other data for the hospital(s) published by the HSCRC.

oFor an existing program, assumptions should be derived from actual experience to the extent possible.

oIf assumptions have been developed from an actuary's proprietary data, the AM need not provide the base data but it should describe the adjustments that were made to that base data and reasons for making those adjustments. For example, the AM might say that hospital utilization has been increased because the expected average age was XX which is YY years more than assumed in the data base.

Adverse or Qualified Opinions

If the appointed actuary is unable to form an opinion, then the actuary shall refuse to issue a statement of actuarial opinion. If the appointed actuary's opinion is adverse or qualified, then the actuary shall issue an adverse or qualified opinion explicitly stating the reason or reasons for the opinion. This statement shall follow the scope paragraph and precede the opinion paragraph.

Reliance on Data Furnished by Other Persons

If the appointed actuary does not express an opinion as to the accuracy and completeness of the listings and summaries of contracts in force or asset oriented information, or both, there shall be attached to the opinion the statement of a company officer or accounting firm who prepared the underlying data identical or similar to the following:

> "I [name, title, company] hereby affirm that the *[listing, summaries, analyses]* related to the data prepared for and submitted to *[name of actuary]* were prepared under my direction and, to the best of my knowledge and belief, are substantially accurate and complete.

_____

Signature of Entity Officer or Accounting Firm

_____

Signature of Entity Officer or Accounting Firm

_____

Telephone Number of Entity Officer or Accounting Firm

Summary of Submission Requirements for Alternative Rate Applications

<table>
<tr><th>Non-Risk</th><th colspan="3">Risk Sharing</th></tr>
<tr><th>PROCEDURE-BASED PRICING</th><th>GLOBAL OR CASE RATE PRICING</th><th>PARTIAL CAPITATION</th><th>FULL CAPITATION</th></tr>
<tr><td rowspan="2">Cost study method and calculations used to determine ancillary cost allocations</td><td colspan="3">Corporate structure, capitalization, and financial statement of risk bearing entity</td></tr>
<tr><td>Cost calculations used to derive global or case pricing</td><td colspan="2">Statement of purpose and distribution of payment under the arrangements</td></tr>
<tr><td>Machine readable versions of data used to compute weighting of cases</td><td>Machine readable versions of data used to compute prices</td><td colspan="2">Description of services provided under the arrangements</td></tr>
<tr><td rowspan="2">Calculations used to develop procedure revenue center and rate (may include banking of revenue)</td><td>Calculation of deviations between proposed and historical charges</td><td rowspan="2">Description of risk pool and incentive provisions</td><td>Statement of Actuarial Opinion and Actuarial Memorandum</td></tr>
<tr><td>Justification of deviations between proposed and historical charges</td><td>Contract templates (between related entity and providers and between related entity and payer)</td></tr>
</table>

SECTION 200
ARM SYSTEM

ALTERNATIVE RATE SETTING MANUAL
SECTION 200
REPORTING REQUIREMENTS AND INSTRUCTIONS

.01 OVERVIEW

The purpose of this section is to describe the reports which are required to be submitted for each approved ARM contract as well as to provide detailed instructions for the Schedules to be completed. The authority for the required reports is contained in Health-General Article, §§19-207, 19-211, and 19-216. The regulations requiring the reports and the penalties that the Commission may impose for those hospitals that fail to comply with ARM reporting requirements are specified in COMAR 10.37.10.06E.

.02 REPORTING REQUIREMENTS

The reporting requirements are listed in sub-sections .021 and .022 below. The detailed instructions and schedules are currently included in Section 500 Reporting Instructions--Accounting and Budget Manual for Fiscal and Operating Management and have been reproduced in sub-sections .03 to .063 below.

A. QUARTERLY REPORTS

(1) Capitation Arrangements

Schedules AR1, Capitation Income and Expense Report, and Schedule AR2, Capitation Utilization Report, shall be completed and filed within 30 days of the end of each calendar quarter beginning the first full quarter after Commission approval of the capitated arrangement. However, if no contract has been executed by that time, AR1 and AR2 schedules shall be filed with the notation "No Contract Executed." Schedules must be filed for each capitation contract. (Thus, for example, if a managed care company has contracts for commercial, Medicare, and Medicaid populations, three separate sets of schedules must be filed.)

(2) Global Price Arrangements

Schedule AR3, Global Price Revenue Report, shall be completed and filed within 30 days of the end of each calendar quarter beginning the first full quarter after Commission approval of the global price arrangement. However, if no contract has been executed by that time, an AR3, schedule shall be filed with the notation "No Contract Executed." A schedule must be filed for each global price arrangement.

SECTION 200
REPORTING REQUIREMENTS AND INSTRUCTIONS

B. ANNUAL REPORTS

(1) Audited Financial Statements - Related Entity

Audited financial statements of the risk-taking related entity shall be filed within 90 days after the end of its fiscal year.

(2) AR1, AR2, and AR3

Annual AR1, AR2, and AR3 schedules shall be filed within 90 days after the end of the risk-taking entity's fiscal year. The annual reports should be reconcilable with the audited financial statement of the related entity.

(3) Special Audit Procedures

Several audit procedures have been added to the Special Audit Procedure. These additional procedures must be performed by an independent CPA firm. Their purpose is to ensure that the information provided on the AR1, AR2, and AR3 schedules is accurate. These additional Special Audit procedures shall be filed 110 days after the end of the related entity's fiscal year.

.03 Schedule D21A - Procedure Based Outpatient Surgery Supplemental Schedule

A. Overview

Schedule D21A is provided to enable hospitals to identify and report the FTE's, costs and volumes of the individual ancillary services that make up the Outpatient Surgery-Procedure Based Center, Schedule D21. The information collected on this schedule when combined with the information on the appropriate D Schedules; Operating Room D24, Anesthesiology D25, Same Day Surgery D22, Medical/Surgical Supplies D26, and Cost of Drugs Sold D27, equal the total number of FTE's, as well as the total n umber of units of service and the cost to produce them for each of the individual ancillary centers. Consolidation of FTE's costs and units of service is necessary so that the ancillary service information may be utilized in analyses, comparisons and rate review methodologies.

The entries on Line L; F.T.E.'s Column 1, Salaries and Fringe Benefits Column 2, Physician Supervision Expenses Column 3, Other Expenses Column 4, and Total Expenses Column 5 shall agree with the applicable totals on Schedules D21, Outpatient Surgery-Procedure Based.

Round the FTE data in Column 1, Line A through L to 1 decimal place, e.g., 22,612 hours divided by 2080 = 10.9.

Round the expenses on Lines A through K in Columns 2 through 5 to one decimal place (nearest hundred), e.g., 66,428.93 is entered as 66.4.

B. Detailed Instructions

Heading Section

SECTION 200
ARM REPORTING INSTRUCTIONS

Institution Name Line

Enter on this line the complete name of the reporting hospital.

Institution Number Line

Enter on this line the number assigned to the reporting hospital. The assigned number corresponds to the last 4 digits of the reporting hospitals Medicare Provider Number, e.g., 0099.

Base Year Line

Enter on this line the year for which the data is reported.

Column 1 - FTE's

Lines A through K

Enter on the appropriate lines the FTE's engaged in providing procedure based outpatient surgery services. FTE's are the result of dividing the hours worked by 2080, e.g., 10,912 divided by 2080 = 5.2.

Column 2 - Salaries and Fringe Benefits

Enter on the appropriate lines the Salaries and Fringe Benefits Expenses incurred in the base year to provide procedure based outpatient surgery services.

Column 3 - Physician Supervision Expenses

Enter on the appropriate lines the physician supervision expenses incurred in the base year to provide procedure based outpatient surgery services.

Column 4 - Other Expense

Enter on the appropriate lines the direct expenses other than salaries and fringe benefits incurred in the base year to provide procedure based outpatient surgery services.

Column 5 - Total Expenses

Enter on the appropriate lines the sum of Columns 2, salaries and fringe benefits Column 3, Physician Expenses and Column 4, other expenses.

Columns 1, 2, 3, 4, and 5

Line L - Totals

Enter on this line in the appropriate column the sum of the entries on Lines A through K.

The entry on Line L, Column 5, Total Expenses shall agree with the entry on Column 4, Line F Total Expenses on Schedule D21 Outpatient Surgery - Procedure Based.

OUT PATIENT SURGERY

D 21A

PROCEDURE BASED

SUPPLEMENTAL SCHEDULE

INSTITUTION NAME _____

INSTITUTION NUMBER _____

BASE YEAR _____

	CODE	CENTER	COL.1 FTE'S	COL.2 SALARIES AND FRINGE BENEFITS	COL.3 PHYS. SUPER-VISION EXPENSES	COL.4 OTHER EXPENSES	COL.5 TOTAL EXPENSES
A	OR	OPERATING ROOM					
B	ANS	ANESTHESIOLOGY					
C	SDS	SAME DAY SURGERY					
D	MSS	MED/SURG SUPPLIES					
E	CDS	DRUGS					
F							
G							
H							
I							
J							
K							
L		TOTAL					

HSCRC
9/95

.04 Schedule AR -1 Capitation Income and Expense Report

A. Overview

Schedule AR-1 is provided to facilitate the reporting of income and expense information associated with managed care capitation arrangements on a calendar quarter and on an annual basis.

All income and expenses for all members covered under the managed care capitation arrangement shall be reported. All income and expenses amounts shall be provided on an accural basis. Information on an incurred or accrued basis may be provided in supplementary notes.

Categories of expenses as reported on lines 10 through 81 are meant to be complete and mutually exclusive. That is, all expenses for services and supplies under the capitation arrangement must be reported in this schedule, and each expense must be reported only once.

Expenses which fall across two or more categories should be allocated using a reasonable approximation which does not systematically understate or overstate any of the categories.

Round all dollar amounts to 1 decimal place (nearest hundred), e.g. 66,428.93 is entered as 66.4.

B. Detailed Instructions

Heading Section

Hospital Name and Number Line

Enter on this line the complete name of the hospital responsible to ensure that this information be filed. Also enter on this line following the hospital's name the number assigned to the responsible hospital in Appendix B. The assigned number corresponds to the last 4 digits of the responsible hospital's Medicare Provider Number, e.g., 0099.

Period Ending Line

Enter on this line the period for which data is reported, e.g., 07-96 - 09/96.

Contact Person

Enter on this line the name of the person responsible for filling in this schedule.

Telephone Number

Enter on this line the telephone number of the person responsible for filling in this schedule.

Reporting Entity Name Line

Enter on this line the complete name of the entity reporting the information.

Payer/Contract Line

Enter on this line the complete name of the payer that has entered into the capitation arrangement with the reporting entity. In addition, enter on this line the contract number or other designation given the capitation arrangement for which this data is report.

Line A - Member Months

Enter on this line the sum of the total number of paid members enrolled in each individual month of the period being reported. Members include all subscribers and all of their covered dependents. For members who enter or leave in the middle of a month, any

reasonable approximation which does not systematically understate or overstate the time enrolled is acceptable.

Column 1 - Income Section

Line 1 - Capitation Income

Enter on this line the total revenue for all members under the capitation arrangement. The amount of revenue reported should correspond to the paid member months reported on Line A.

Line 2 - Reinsurance Recoveries

Enter on this line all income from reinsurance recovery payments.

Line 3 - Other Income

Enter on this line all other income not reported on lines 1 and 2 above. Please provide a detailed description of the source and amounts of all income reported on this line.

Line 4 - Total Income

Enter on this line the sun of lines 1, 2 and 3 above.

Column 1 - Expense Section

Lines 10 to 14 - Total Inpatient Facility Expenses

Enter on these lines, in the total column, the expenses for inpatient facility expenses excluding mental health and substance abuse expenses.

Line 10 - Medical/Surgical - Acute, Pediatric - Acute and Definitive Observation

Enter on this line, in the total column, inpatient facility expenses for acute medical, surgical, pediatric, and definitive observation centers. Expenses for maternity centers or newborn nurseries should **NOT** be included here, but should be reported in Line 12.

Line 11 - Tertiary Care Expenses

Enter on this line the inpatient facility expenses for intensive care units, cardiac care units, trauma care units, burn centers, neo-natal intensive care units etc.

Line 12 - Maternity and Newborn Expenses

Enter on this line the inpatient facility expenses for obstetric units, birthing centers and newborn nurseries.

Line 13 - Rehabilitation Expenses

Enter on this line the inpatient facility expenses for physical rehabilitation units and facilities.

Line 14 - Extended Care Expenses

Enter on this line the inpatient extended care facility expenses, including expenses for care provided in skilled nursing facilities, intermediate care facilities, long term care facilities, hospices, and chronic hospital centers.

Lines 20 to 24 - Outpatient Facility Expenses

Enter on these lines, in the Total Column, the expenses for outpatient facility services excluding mental health and substance abuse expenses.

Line 20 - Ambulatory Services Expenses

Enter on this line the facility expenses for hospital based same day surgery centers and freestanding ambulatory surgery centers.

Line 21 - Emergency Department Expenses

Enter on this line the facility expenses for emergency departments, freestanding emergency services centers, outpatient trauma centers.

Line 22 - Imaging Expenses

Enter on this line the outpatient hospital-based and free-standing facility expenses for diagnostic imaging services (radiology, ultrasound, nuclear medicine, etc.).

Line 23 - Primary Care Expenses

Enter on this line the facility expenses for outpatient primary care services such as urgent care.

Line 24 - Other Expenses

Enter on this line the other outpatient facility expenses not included in the list above (except for psychiatric or substance abuse services which should be reported in lines 51 and 61). This includes specialty centers or facilities such as outpatient curative centers (chemotherapy, transfusions, etc.) and outpatient therapeutic centers (physical therapy, cardiac rehabilitation, etc.).

Lines 30 to 34 - Professional Services Expenses

Enter on these lines, in the Total Column, the expenses for Professional Services excluding mental health and substance abuse expenses.

Line 30 - Primary Care Expenses

Enter on this line the professional provider expenses for routine evaluation, management, and preventive care (except for maternity and newborn care which should be included in Line 33).

Primary care services include CPT codes:

Office/Outpatient Services:	99201-99205,99211-99215
Preventive Medicine:	99381-99429,99499
Immunization Injections:	90701-90749

Line 31 - Imaging Expenses

Enter on this line the professional provider expenses for diagnostic imaging services, including radiology, ultrasound, diagnostic nuclear medicine.

Imaging Services include CPT codes:

Diagnostic Radiology:	70010-76499
Diagnostic Ultrasound:	76506-76999
Nuclear Medicine:	78000-78999

Line 32 - Pathology (Surgical) Expenses

Enter on this line the professional provider expenses for surgical pathology. Surgical pathology services include CPT codes: 88300-88399

Line 33 - Maternity and Newborn Expenses

Enter on this line the professional provider expenses for maternity care and delivery, including all antepartum, delivery, and postpartum care for mother and newborn as well as fertility services and termination of pregnancy. Expenses for medical or surgical complications of pregnancy should also be included in this section.

Maternity services include CPT codes:

Maternity Care/Delivery:	59000-59899, 00857, 00995, 00850, 00946, 99150-51
Newborn Care:	99431-33, 99438-40, 54150 54160, 94652, 54000,36450, 36510,36660
Fertility Services:	58970-76, 89300-20, 89329, 89330

Line 34 - Other Specialists Expenses

Enter on this line the expenses for all other medical and surgical professional provider services, as well as consultations, and anesthesia services.

Other specialists services include CPT codes:

Anesthesia:	00100-01999
Surgery:	10040-58999, 60000-69979
Radiation Oncology:	77261-77799
Therapeutic Nuclear:	79000-7999
Medicine:	90780-90799, 90900-99199
Hospital Inpatient:	99221-99238
Consultations:	99241-99275
Emergency Care:	99281-99288
Critical Care:	99291,99292,99295-99297
Medicine:	90780-90799, 90900-99199

Lines 40 to 44 - Non-Facility Expenses

Enter on these lines, in the Total Column, the expenses for Non-Facility Expenses.

Line 40 - Pharmacy Expenses

Enter on this line the expenses for pharmacy services and pharmaceuticals that are not included in the inpatient or outpatient facility charges reported above.

Line 41 - Laboratory Expenses

Enter on this line the expenses for pathology and laboratory services that are provided by the pathologist or by technologists. This line should include only those expenses that are **not** included in the facility or professional expenses reported above. Expenses for surgical pathology services should be included in Line 34. Laboratory and Pathology services include CPT codes: 80002-88299, 89050-89399.

Line 42 - Durable Medical Equipment and Prosthetics

Enter on this line all expenses for the sale, rental, fitting, or testing of durable medical equipment or prosthetics that are **not** included in facility or professional expenses reported above.

Line 43 - Home Health Care

Enter on this line all expenses for services and supplies for home health care services. Home Health Care Services include CPT codes: 99341-99353.

Line 44 - Other Expenses

Enter on this line all expenses for non-facility supplies and services that are not already reported in Lines 40 to 43, including ambulance fees.

Lines 50 to 53 - Mental Health Expenses

Enter on these lines, in the Total Column, the expenses for Mental Health Services. Include all expenses for services and supplies provided in a psychiatric hospital or unit, or by a mental health provider other than treatment for substance abuse.

Psychiatric CPT codes, 90801-90899, are not separated by inpatient and outpatient services.

Lines 50 - Inpatient Facility Expenses

Enter on this line the facility expenses for all mental health inpatient services and supplies, including expenses for psychiatric units and facilities.

Line 51 - Outpatient Facility Expenses

Enter on this line the facility expenses for all mental health outpatient services and supplies, including centers and facilities for psychiatric day/night care, partial hospitalization, and outpatient psychiatric therapy.

Line 52 - Inpatient Professional Expenses

Enter on this line the professional expenses for all providers that perform inpatient mental health services, including psychiatrists, psychologists, psychiatric nurses, social workers, rehabilitation counselors, and other providers giving care in an inpatient mental health care setting.

Line 53 - Outpatient Professional Expenses

Enter on this line the professional expenses for all providers that perform outpatient or partial hospitalization mental health services, including psychiatrists, psychologists, psychiatric nurses, social workers, rehabilitation counselors, and other providers giving care in an outpatient mental health care setting.

Lines 60 to 63 - Substance Abuse Expenses

Enter on these lines, in the Total Column, the expenses for Substance Abuse.

Line 60 - Inpatient Facility Services

Enter on this line the facility expenses for all substance abuse inpatient services and supplies, including expenses for substance abuse units and facilities.

Line 61 - Outpatient Facility Services

Enter on this line the facility expenses for all substance abuse outpatient services and supplies, including centers and facilities for substance abuse day/night care, partial hospitalization, and outpatient treatment.

Line 62 - Inpatient Professional Services

Enter on this line the professional expenses for all providers that perform inpatient substance abuse services, including psychiatrists, psychologists, psychiatric nurses, social workers, rehabilitation counselors, and other providers giving care in an inpatient substance abuse care setting.

Line 63 - Outpatient Professional Services

Enter on this line the professional expenses for all providers that perform outpatient or partial hospitalization substance abuse services, including psychiatrists, psychologists, psychiatric nurses, social workers, rehabilitation counselors, and other providers giving care in an outpatient substance abuse care setting.

Column 2 - Capitated Expenses/Related Entity

Lines 10 through 63

Enter on each applicable line all the expenses paid under a capitated arrangement to a related entity, as defined in COMAR 10.37.12(B)(4). Include salaries, expenses, and related benefits of employees who provide direct medical services to patients. Do not include the cost of utilization review, case management, health education, medical director or related services.

Column 3 - Capitated Expenses/Unrelated Entity

Lines 10 through 63

Enter on each applicable line all the expenses paid under a capitated arrangement to an unrelated entity.

Column 4 - Fee for Service Expenses/In - Network

Lines 10 through 63

Enter on each applicable line all the expenses paid on a fee for service basis to providers who are members of the reporting entity's provider network.

Column 5 - Fee for Service/Out of Network

Lines 10 through 63

Enter on each applicable line all the expenses paid on a fee for services basis to providers located in the network area, but which are not members of the reporting entity's provider network.

Column 6 - Fee for Service/Out of Area

Lines 10 through 63

Enter on each applicable line all the expenses paid on a fee for service basis to providers located outside the reporting entity's network area.

Columns 1 through 6 - Expenses

Line 70 - Total Medical Costs

Enter on this line, in each column, the result of adding the expenses from lines 10 to 63. The sum of the entries in Columns 2 to 6, Line 70, should equal the entry in Column 1, Line 70.

Line 71 - Global Fee Costs

Enter on this line from Schedule AR3 the total "Global Fee" paid. (This line shall be utilized only when the reporting entity has a managed care capitation arrangement and a "Global Fixed Price" arrangement the results of which are both reported to the HSCRC. Other global fees should be allocated to a category on lines 10 to 63 using a reasonable approximation which does not understate or overstate the entry for any of the categories. The amounts should be placed in column 2 or column 3 as appropriate.)

Line 72 - Total Claim Costs

Enter on this line the sum of lines 70 and 71. This line represents the total direct costs associated with claims.

Lines 80 and 81 - Other Expenses

Line 80 - Administration Expenses

Enter on this line all other expenses including, but not limited to, expenses for utilization review, case management, member services, health education, financial management, claim processing, contract management and marketing.

Line 81 - Reinsurance Expenses

Enter on this line all expenses for reinsurance, including specific and aggregate stop-loss coverage premiums and capitation hold-backs.

Line 82 - Total Expenses

Enter on this line the sum of lines 72, 80 and 81.

Line 89 - Net Income (Loss)

Enter on this line the difference between line 4, Total Income, and Line 82 Total Expenses.

SCHEDULE AR–1

AR–1a

INCOME & EXPENSE REPORT

HOSPITAL
NAME AND NUMBER_____.

REPORTING ENTITY_____.

PAYOR/CONTRACT_____ QUARTER ENDING_____

A	MEMBER MONTHS						
		TOTAL					
		COL. 1	COL.2	COL.3	COL.4	COL.5	COL.6
1	CAPITATION INCOME						
2	REINSURANCE RECOVERIES		CAPITATED		FEE–FOR SERVICE		
3	OTHER INCOME		RELATED ENTITY	UNRELATED ENTITY	IN–NETWORK	OUT–OF NETWORK	OUT–OF AREA
4	TOTAL INCOME						
	INPATIENT FACILITY	/////	/////	/////	/////	/////	/////
10	MED/SURG/PED						
11	TERTIARY CARE(ICU/CCU,ETC.)						
12	MATERNITY						
13	REHABILITATION						
14	EXTENDED CARE						
	OUTPATIENT FACILITY	/////	/////	/////	/////	/////	/////
20	AMBULATORY SURGERY						
21	EMERGENCY DEPARTMENT						
22	IMAGING						
23	CLINIC						
24	OTHER						
	PROFESSIONAL	/////	/////	/////	/////	/////	/////
30	PRIMARY CARE						
31	IMAGING						
32	PATHOLOGY						
33	MATERNITY						
34	OTHER SPECIALISTS						
	NON–FACILITY	/////	/////	/////	/////	/////	/////
40	PHARMACY						
41	LABORATORY						
42	DME & PROSTHETICS						
43	HOME HEALTH CARE						
44	OTHER (INCL. AMBULANCE)						

SCHEDULE AR-1
INCOME & EXPENSE REPORT

AR-1b

		COL. 1	COL. 2	COL. 3	COL. 4	COL.5	COL.6
	MENTAL HEALTH	/////	/////	/////	/////	/////	/////
50	FACILITY, INPATIENT						
51	FACILITY OUTPATIENT						
52	PROFESSIONAL, INPATIENT						
53	PROFESSIONAL,OUTPATIENT						
	SUBSTANCE ABUSE	/////	/////	/////	/////	/////	/////
60	FACILITY, INPATIENT						
61	FACILITY, OUTPATIENT						
62	PROFESSIONAL, INPATIENT						
63	PROFESSIONAL, OUTPATIENT						

70	TOTAL MEDICAL COSTS						
71	GLOBAL FEE COSTS						
72	TOTAL CLAIM COST						
	OTHE EXPENSES & INCOME	/////					
80	ADMINISTRATION						
81	REINSURANCE PAYMENTS						
82	TOTAL EXPENSES						
90	***NET INCOME (LOSS)***						

DATA PROVIDED ON THIS REPORT IS CONSIDERED CONFIDENTIAL COMMERCIAL INFORMATION

.05 Schedule AR-2 - Capitation Utilization Report

A. Overview

Schedule AR-2 is provided to facilitate the reporting of utilization information associated with capitation arrangements on a calendar quarter and on an annual basis.

Round the entries in columns 2 and 3 to 2 decimal places, e.g., 10,241 / 7,564 = 1.35.

The entries in lines 10 to 63 should be reported in a manner consistent with the expenses reported in Schedule AR-1.

B. Detailed Instructions

Heading Section

Hospital Name and Number Line

Enter on this line the complete name of the hospital responsible to ensure that this information be filed. In addition, enter on this line the number assigned to the responsible hospital. The assigned number corresponds to the last 4 digits of the responsible hospital's Medicare Provider Number, e.g., 0099.

Reporting Entity Name Line

Enter on this line the complete name of the entity reporting the information.

Payer/Contract Line

Enter on this line the complete name of the payer that has entered into the capitation arrangement with the reporting entity. In addition, enter on this line the contract number or other designation given the capitation arrangement for which this data is report.

SECTION 200
ARM REPORTING INSTRUCTIONS

Period Ending Line

Enter on this line the period for which this information is reported, e.g., 07/96 - 9/96.

Contact Person

Enter on this line the name of the person responsible for filling in this schedule.

Telephone Number

Enter on this line the telephone number of the person responsible for filling in this schedule.

Column 1 - Number of Units of Service

Describe any units reported that differ from those prescribed in these instructions.

Lines 10 to 14 - Inpatient Facility Units of Service

Enter on each applicable line the appropriate number of inpatient days.

Lines 20 to 23 - Outpatient Facility Units of Service

Enter on each applicable line the appropriate number of outpatient units of service.

Lines 30 to 34 - Professional Services Units of Service

Enter on the applicable line the appropriate number of professional units of service.

Lines 40 to 44 Non-Facility Units of Service

Enter on each applicable line the appropriate number of non-facility units of service.

Lines 50 to 53 Mental Health Units of Service

Enter on each applicable line the appropriate number of mental health units of service.

Lines 60 to 63 Substance Abuse Units of Service

Enter on each applicable line the appropriate number of substance abuse units of service.

Lines 90 to 93 Inpatient Admissions

Enter on the applicable line the appropriate number of admissions.

(Enter the number of admissions which correspond to the patient days reported on the appropriate prior lines of the schedule. That is, admissions on Line 90 correspond to patient days on Line 50; admissions on Line 91 correspond to patient days on Line 60; admissions on Line 92 correspond to patient days on Lines 10 to 13 and admissions on Line 93 correspond to patient days on Line 14.)

Column 2 - Average Unit cost

Lines 10 to 63

Enter on each applicable line the result of dividing the total cost, as reported in Column 1 of Schedule AR-1, by the total number of units of service on the appropriate line in Column 1 of this schedule, Schedule AR-2.

Column 3 - Number of Units Per Member Per Month

Lines 10 to 63

Enter on each applicable line the result of dividing the total units of service as reported in Column 1 of this schedule, Schedule AR-2, by the number of Member Months as reported on Line A of Schedule AR-1.

.05 C

SCHEDULE AR-2
UTILIZATION REPORT

AR-2

HOSPITAL NAME AND NUMBER_____

024

REPORTING ENTITY_____

PAYOR/CONTRACT_____

QUARTER ENDING_____

			COL 1	COL 2	COL3
		UNITS OF SERVICE	NUMBER OF UNITS	AVERAGE UNIT COST	NUMBER OF UNITS PMPM
	INPATIENT FACILITY	/////	/////	/////	/////
10	MED/SURG/PED	DAYS			
11	TERRIARY CARE(ICU/CCU,ETC)	DAYS			
12	MATERNITY	DAYS			
13	REHABILITATION	DAYS			
14	EXTENDED CARE	DAYS			
	OUTPATIENT FACILITY	/////	/////	/////	/////
20	AMBULATORY SURGERY	PROCEDURES			
21	EMERGENCY DEPARTMENT	VISITS			
22	IMAGING	PROCEDURES			
23	OTHER				
	PROFESSIONAL	/////	/////	/////	/////
30	PRIMARY CARE	VISITS			
31	IMAGING	PROCEDURES			
32	MATERNITY	DELIVERIES			
33	OTHER SPECIALISTS				
	NON-FACILITY	/////	/////	/////	/////
40	PHARMACY	SCRIPTS			
41	LABORATORY	PROCEDURES			
42	DME & PROSTHETICS	ITEMS			
43	HOME HEALTH CARE	VISITS			
44	OTHER (INCL. AMBULANCE)				
	MENTAL HEALTH	/////	/////	/////	/////
50	FACILITY, INPATIENT	DAYS			
51	FACILITY, OUTPATIENT	VISITS			
52	PROFESSIONAL, INPATIENT	VISITS			
53	PROFESSIONAL, OUTPATIENT	VISITS			
	SUBSTANCE ABUSE	/////	/////	/////	/////
60	FACILITY, INPATIENT	DAYS			
61	FACILITY, OUTPATIENT	VISITS			
62	PROFESSIONAL, INPATIENT	VISITS			
63	PROFESSIONAL, OUTPATIENT	VISITS			
	ADMISSIONS	/////	/////	/////	/////
70	MENTAL HEALTH	ADMISSIONS			
71	SUBSTANCE ABUSE	ADMISSIONS			
72	OTHER INPATIENT	ADMISSIONS			
73	EXTENDED CARE	ADMISSIONS			

DATA PROVIDED ON THIS REPORT IS CONSIDERED CONFIDENTIAL COMMERCIAL INFORMATION.

.06 Schedule AR-3 - Global Price Revenue Report

A. Overview

Schedule AR-3 is provided to facilitate the reporting of revenue and volume information associated with global price arrangements on a calendar quarter and on an annual basis.

Round the entries in Columns 4, Hospital Changes, 5 Global Payment and 6 Difference to 1 decimal place (nearest hundred) e.g., 66,428.93 is entered as 66.4.

B. Detailed Instructions

Heading Section

Hospital Name and Number Line

Enter on this line the complete name of the hospital responsible to ensure that this information be filed. In addition, enter on this line the number assigned to the responsible hospital. The assigned number corresponds to the last 4 digits of the responsible hospital's Medicare Provider Number, e.g., 0099.

Reporting Entity Name Line

Enter on this line the complete name of the entity reporting the information.

Payer/Contract Line

Enter on this line the complete name of the payer that has entered into the capitation arrangement with the reporting entity. In addition, enter on this line the contract number or other designation given the capitation arrangement for which this data is reported.

Period Ending Line

Enter on this line the date on which the calendar quarter for which this information was reported ended, e.g., 07/96 - 0/96.

Contact Person

Enter on this line the name of the person responsible for filling in this schedule.

Telephone Number

Enter on this line the telephone number of the person responsible for filling this schedule.

Columns 1 - DRG/Procedure

Lines 1 through 22

Enter into this column on separate lines the appropriate DRG or procedure, as delineated in the global price contract or arrangement.

Column 2 - Number of Cases

Lines 1 through 22

Enter on each applicable line the appropriate number of cases for the period.

Column 3 - Number of Days

Lines 1 through 22

Enter on the applicable line the total number of inpatient days associated with the cases recorded in column 2.

Column 4 - Hospital Charges

Lines 1 through 22

Enter on the applicable line the total HSCRC regulated charges, both inpatient and outpatient, associated with the cases as reported in column 1.

Column 5 - Global Payment

Lines 1 through 22

Enter on the applicable line the total global payments for medical services provided under the global price contract or arrangement for the cases in column 1. Medical services may include, but not be limited to, inpatient and outpatient hospital services as well as physicians professional services.

Column 6 - Difference

Lines 1 through 22

Enter on the applicable line the result of subtracting the Hospital Charges in Column 4 from the Global Payments in Ccolumn 5.

Columns 2, 3, 4, 5 and 6

Lines 23 - Totals

Enter on this line in the appropriate column the sum of lines 1 through 22. This line represents the total number of cases, the total number of patient days, the total hospital charges, the total global payments and the total difference between the global payments and the hospital charges.

SCHEDULE AR–3
GLOBAL PRICE REVENUE REPORT

HOSPITAL
NAME AND NUMBER_____

REPORTING ENTITY_____

PAYOR/CONTRACT_____

QUARTER
ENDING_____

	COL 1	COL 2	COL 3	COL 4	COL 5	COL 6
	DRG/PROCEDURE	NUMBER OF CASES	NUMBER OF DAYS	HOSPITAL CHARGES	GLOBAL PAYMENT	DIFFERENCE
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
16						
17						
18						
19						
20						
21						
22						
23	TOTAL					

DATA PROVIDED ON THIS REPORT IS CONSIDERED CONFIDENTIAL COMMERCIAL INFORMATION.