STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

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Trudy R. Hall, M.D.
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452nd MEETING OF THE HEALTH SERVICES COST REVIEW COMMISSION

EXECUTIVE SESSION

9:00 a.m.

1. **Follow up on a Previous Comfort Order Determination**
2. **Consultation with Legal Counsel Regarding Commission Authority to Review the Credit & Collection Policies of Maryland Hospitals**

PUBLIC SESSION OF THE

HEALTH SERVICES COST REVIEW COMMISSION

January 14, 2009

9:30 a.m.

1. **Review of the Public Minutes of December 10, 2008**
2. **Executive Director's Report**
3. **Docket Status - Cases Closed**

   1999A - University of Maryland Medical Center
   2007R - Johns Hopkins Bayview Medical Center
   2008A - Johns Hopkins Health System
   2010A - MedStar Health

4. **Docket Status - Cases Open**

   1985A - University of Maryland Medical Center
   2009A - University of Maryland Medical Center
   2011R - Baltimore Washington Medical Center
   2012A - Johns Hopkins Health System

5. **Draft Recommendations on Changes to ICC/ROC Methodologies**
6. **Review of Additional Elements to be Included in the Inpatient and Outpatient Discharge Data Collection**
7. **Request by Medical Assistance program to Suspend Reconciliation of Current Financing Deposits**
8. **Staff Recommendation - Kennedy Krieger Reporting Requirements**
9. **Legal Report**
10. **Hearing and Meeting Schedule**

451st MEETING OF THE
HEALTH SERVICES COST REVIEW COMMISSION

DECEMBER 10, 2008

Chairman Young called the meeting to order at 9:01 a.m. Commissioners Joseph R. Antos, Ph.D., Raymond J. Brusca, J.D., Trudy R. Hall, M.D., James Lowthers, Kevin J. Sexton, and Herbert Wong, Ph.D., were also present.

ITEM I
REVIEW OF THE MINUTES OF THE EXECUTIVE AND PUBLIC SESSIONS OF NOVEMBER 5, 2008

The Commission voted unanimously to approve the minutes of the November 5, 2008 Executive Session and Public Meeting.

ITEM II
EXECUTIVE DIRECTOR'S REPORT

Robert Murray, Executive Director, reported to the Commission on the status of major initiatives and issues. Mr. Murray stated that: 1) although there were delays in compiling and analyzing individual hospital data associated with the Maryland Hospital Acquired Conditions, the workgroup continued to work on payment policy approaches; 2) the Quality-Based Reimbursement workgroup is reviewing the incorporation of additional process measures, as well as examining outcome/and patient experience of care measures; 3) staff is working on payment simulation associated with preventable conditions and preventable re-admissions; 4) discussions on the 3 year Payment Arrangement have begun and staff is waiting for proposals from the hospital industry and the payers; 5) staff will be assembling a group in January to evaluate this year's Community Benefit Reports and provide feed-back to both the hospitals and the Commission; and 6) staff is reviewing the potential revision of the chronic hospitals' payment system in response to the Department of Health and Mental Hygiene's budget crisis.

John O'Brien informed the Commission that the draft ICC/ROC policy recommendation will not be presented today but will be ready for the January 2009 public meeting.

Mr. Murray introduced the newest member of the Commission's staff Christopher Konsowski. Mr. Konsowski was an auditor for Maryland's Medicare Intermediary for nine years. Most recently, he performed audits of psychiatric hospitals and residential treatment centers, including establishing Medicaid interim rates for the Maryland Medicaid contractor, Myers and Stauffer. Mr. Konsowski assumes the position of Hospital Rate Analyst.

ITEM III
DOCKET STATUS CASES CLOSED

1994A – Johns Hopkins Health System

2006A – Johns Hopkins Health System

ITEM IV
DOCKET STATUS CASES OPEN

University of Maryland Medical Center – 1999A

On July 31, 2008, the University of Maryland Medical Center filed an application for approval for its continued participation in a global rate arrangement for solid organ and bone marrow transplants with Maryland Physicians Care for a period of three years retroactive to September 1, 2008.

Because the experience under this arrangement was favorable over the last year, staff recommended approval of the Hospital's request for continued participation in the global price arrangement for a one year period, retro-active to September 1, 2008. In addition, staff recommended that the approval be contingent on the execution of the standard Memorandum of Understanding.

The Commission voted unanimously to approve staff's recommendation.

Johns Hopkins Health System – 2008A

On November 17, 2008, the Johns Hopkins Health System filed an application on behalf of Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, and Howard County General Hospital, requesting approval to continue to participate in a global rate arrangement for solid organ and bone marrow transplant services with Coventry Transplant Network for a period of three years effective December 1, 2008.

Because the case rates were updated and the experience under this arrangement was favorable over the last year, staff recommended that the Commission approve the request for a one year period, effective December 1, 2008, and that the approval be contingent upon the execution of the standard Memorandum of Understanding.

The Commission voted unanimously to approve staff's recommendation.

MedStar Health – 2010A

On December 1, 2008, MedStar Health filed an application on behalf of Union Memorial Hospital requesting approval to continue to participate in a global rate arrangement for orthopedic services with the NFL Player Joint Replacement Benefit Plan for a period of one year effective December 1, 2008.

Although there has been no activity reported, staff continues to believe that the Hospital can achieve favorable performance under this arrangement. Therefore, staff recommended that the Commission approve the Hospital's request for continuation of the arrangement for one year effective December 1, 2008, and that the approval be contingent upon the execution of the standard Memorandum of Understanding.

The Commission voted unanimously to approve staff's recommendation.

ITEM V
FINAL RECOMMENDATION - CHANGES TO THE UNCOMPENSATED CARE FUNDING METHODOLOGY

Mr. Murray stated that the idea to develop a broader and more equitable financing of uncompensated care (UCC) burden has been considered for a long time, and in1994, the Commission received legislative authorization to do so. As a first step, a compromise partial pooling of UCC methodology was implemented. Now, the industry is moving to what was originally contemplated, full pooling of UCC, which shares the burden of UCC most broadly and most equitably.

Mr. Murray noted that there is one slight change from the draft recommendation for modifying the Commission's mechanism for funding uncompensated care (UCC). Staff is awaiting word from the AELR Committee on the effective date of the amendment to the regulation to implement the change in methodology. If the effective date of the amended regulation is made retroactive to December 1st, the move to full pooling of UCC can be made in December 2008 rather than January 2009. This would save the Medicaid Program an additional $400,000 to $500,000.

Staff's final recommendation was that contingent upon an effective date of December 1st for the amended regulation: 1) 100% of all approved levels of UCC would be pooled effective December 2008; 2) beginning December 2008 the mark-ups of high UCC hospitals would be lowered to the state-wide UCC level; 3) also beginning December 2008, the high UCC hospitals would receive monthly 1/12 of the difference between their approved UCC level and the state-wide level from the UCC fund; 4) beginning in January 2009, low UCC hospitals will remit monthly to UCC Fund 1/12 of the difference between its approved UCC level and the state-wide UCC level; and 5) staff would work closely with hospitals and payers to ensure that the proposal

is revenue neutral and cash flow neutral.

Mr. Murray noted that full pooling, although revenue neutral to hospitals, will save Medicaid money because it re-distributes the financing of UCC in a broader way.

Commissioner Sexton asked Mr. Murray to elaborate on how full pooling saves Medicaid money.

Mr. Murray explained that hospitals, particularly those in the inner city, that have the largest percentage of Medicaid patients, also have the highest UCC provisions in their rate structures, and Medicaid pays those higher rates. However, by redistributing the UCC burden equally across hospitals, the UCC provision in the rates of hospitals with a high percentage of Medicaid patients is lowered, and Medicaid, therefore, pays less.

The Commission voted unanimously to approve staff's recommendation.

ITEM VI
OVERVIEW OF THE RECOMMENDATIONS OF THE TASK FORCE ON HEALTH CARE ACCESS AND REIMBURSEMENT

Ben Steffen, Deputy Director-Data Systems of the Maryland Health Care Commission, presented an overview of the draft report of the Task Force on Health Care Access and Reimbursement on approaches to promote primary care physician practice formation in Maryland and in particular the recommendations (attachment B) pertaining to the HSCRC.

Mr. Steffen reported that over the last two years, two task forces have been studying physician access, reimbursement, and supply issues. The first task force looked at several issues including lower physician compensation because of insurance market concentration, the market for physician services, performance systems implemented by payers, and the amount of UCC contributed to physician supply and access in Maryland. The second task force focused on physician access, reimbursement, and supply issues in rural areas.

Among their recommendations, the task forces proposed that the HSCRC establish a program to allow primary care physicians practicing in state-defined shortage areas to be eligible for student loan repayment in exchange for a commitment to practice in the shortage area. Under the recommendation the Commission should establish the program provided that: 1) it is in the public interest; 2) is not in violation of the state's Medicare waiver; and 3) it does not result in significantly increasing costs to Medicare or places the Medicare waiver in jeopardy. The program would be funded by all payers through an amount included in hospital rates not to exceed 0.1 percent of hospital net patient revenue. In addition, rate setting funds may also potentially be utilized for a "grow your own program," i.e., a program to establish scholarship programs for medical students who agree to return and practice in underserved rural areas for 3 to

5 years.

The task forces suggested several funding models to implement the loan repayment program, including: 1) a Nurse Support Program I approach, i.e., one that provides additional funding to hospitals based on detailed proposals for use of funds; 2) a Nurse Support Program II approach, i.e., one that establishes a fund within the Maryland Higher Education Commission, which utilizes its expertise to administer the program; and 3) a fund within the HSCRC as utilized for other HSCRC programs.

The Chairman asked Mr. Steffen to explain why the HSCRC, a hospital rate setting body, should be involved with funding an initiative benefiting physicians not employed by hospitals.

Mr. Steffen replied that 30 states have established loan repayment programs. Since this program is targeted at under-served areas, the rationale for using hospital funds is that hospitals need an adequate supply of physicians so that they can operate effectively.

The Chairman directed Mr. Murray to come back to the Commission with an analysis of the proposed program.

ITEM VII
LEGAL REPORT

Regulations

Proposed

Uniform Accounting and Reporting System for Hospitals and Related Institutions – COMAR 10.37.01.02

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

Rate Application and Approval Procedures - COMAR 10.37.10.26

The purpose of this action is to require hospitals to file their internal and external credit and collection policies with the Commission annually and to authorize penalties for failure to file on a timely and completed basis.

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

Final Adoption

Rate Application and Approval Procedures – 10.37.10.04-2

The purpose of this action is to include a description of the Commission's new outpatient Charge-per-Visit methodology within the existing case target methodology description.

The Commission voted unanimously to adopt the amended regulation.

ITEM VIII
HEARING AND MEETING SCHEDULE

January 14, 2009	Time to be determined, 4160 Patterson Avenue, HSCRC Conference Room
February 4, 2009	Time to be determined, 4160 Patterson Avenue, HSCRC Conference Room

There being no further business, the meeting was adjourned at 9:54 a.m.

Attachment A

Final Staff Recommendations regarding Modifications to the HSCRC's Mechanism for Financing Uncompensated Care

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December 10, 2008

This document represents a final recommendation presented to the Commission December 10, 2008

Background

Since its inception the Health Services Cost Review Commission (the "HSCRC" or "Commission") has recognized the reasonable cost of uncompensated care ("UC") as part of a hospital's full financial requirements. Indeed, the need to finance care to the uninsured was one major health policy concern leading to the formation of the hospital rate setting system in the 1970s. Equitable financing of hospital UC is made possible because of the State's unique Medicare waiver and has traditionally been accomplished by adding a "reasonable" provision in the approved rates of every hospital. The magnitude of each hospital's UC provision (or "add-on") is a function of the characteristics of the patients its serve. As expected, hospitals in areas with relatively larger numbers of uninsured patients generate higher levels of UC and have higher provisions in their rates to cover this burden.

Studies on Alternative Financing of Hospital UC

As hospital uncompensated care has increased in both relative and absolute terms the General Assembly and the HSCRC have been actively involved in efforts to modify and improve the UC funding mechanism. In 1992, following the elimination of the Medicaid State Only program, in response to State budget deficits, General Assembly passed HB 924, which instructed the HSCRC to study alternative methodologies in order to "promote the equitable distribution of the cost of uncompensated care among hospitals." HB 924 also gave the Commission the authority to implement an "alternative financing mechanism." The task force created by the Commission (the 1992 UC Task Force), which included broad representation from hospitals and payers in the State, concluded that the pooling of uncompensated care represented the most appropriate way of ensuring an equitable financing of the UC burden throughout the hospital system.

The 1992 UC Task Force was aware of issue related to the federal ERISA law that raised questions as to the authority of states to establish a regional pooling mechanism of this nature. For this reason, it was recommended that the Commission delay implementation of the UC pool until the ERISA issues were resolved. In April of 1995, the Supreme Court of the United States handed down its decision in the "Travelers" case, which affirmed the ability of states to required self-insured plans to participate in pooling mechanism. This effectively cleared the way for the HSCRC to resolve outstanding technical and rate-setting issues surrounding the pooling initiative.

UC Pooling Compromise and Implementation

In 1996 however, the Maryland Hospital Association (the "MHA") adopted a new policy which raised objections to the full pooling approach. In order to forge a compromise and move ahead with the pooling concept the Commission adopted and implemented a "partial pooling" approach. This approach enabled the HSCRC to create a UC fund or pool from an assessment of 0.75% on each hospital. This assessment generated a fund of approximately $90 million each year. This fund then was reallocated to the subset of hospitals with the highest levels of UC in their rates. Those "high" UC hospitals then would finance their UC burdens in part through their

rate structure (UC provisions in their rates up to some pre-determined threshold level) and in part from payments from the UC pool. This approach did result in a more equitable financing of the UC burden in the system and reduced the range in the UC provisions in rates from hospital to hospital, but it stopped short of 100% pooling of hospital UC. Table 1 provides a simplified and illustrative example of the Partial Pooling approach adopted in 1997 (which is currently still in effect).

Table 1
Example of Partial Pooling

Annual Patient Revenue	$11.0 Billion
State-wide Assessment	0.75% on all Hopsitals
Generates a UC Pool	$83 million
Annual Hospital UC	$770 million
State-wide Average UC	7.0%
Pre-determied UC Threshold	8.5%

Partial Pooling

High UC Hospitals	Policy Determined UC Provisions (in rates)	UC Provision (in rates)	Pool Assessment	Total UC (in rates)	Payment from UC Pool
Hospital 1	14.0%	8.5%	0.75%	9.25%	5.50%
Hospital 2	12.0%	8.5%	0.75%	9.25%	3.50%
Hospital 3	10.0%	8.5%	0.75%	9.25%	1.50%
Hospital 4	9.0%	8.5%	0.75%	9.25%	0.50%
Hospital 5	8.7%	8.5%	0.75%	9.25%	0.20%
Low UC Hospitals	Policy Determined UC Provisions	UC Provision (in rates)		Total UC (in rates)	
Hospital 1	5.0%	5.0%	0.75%	5.75%	0.00%
Hospital 2	4.0%	4.0%	0.75%	4.75%	0.00%
Hospital 3	3.5%	3.5%	0.75%	4.25%	0.00%
Hospital 4	3.0%	3.0%	0.75%	3.75%	0.00%
Hospital 5	2.0%	2.0%	0.75%	2.75%	0.00%

2008 Budget Deficits and Request from the Secretary of Health

In October of this year, in reaction to growing State budget deficits stemming from slowing economic activity and reduced State revenues, the Secretary of Health asked the staff of the HSCRC to identify modifications to the rate system that would help reduce Medicaid expenditures. In contrast to previous such requests from the Department of Health and Mental Hygiene however, there was a priority placed on focusing on initiatives that would encourage a reduction in unnecessary or inappropriate care and/or other mechanisms that could reduce Medicaid expenditures without substantially cutting hospital payments. Yet, the Secretary also

articulated a desire to avoid the use of previously employed mechanisms that reduced Medicaid expenditures by arbitrarily shifting costs to other payers (as had been done in 1991 with the elimination of the Medicaid State Only program and in 2003-2008 with the imposition of Medicaid Day Limits). Future initiatives to facilitate reductions in Medicaid expenditures should be designed based on some overarching policy rationale and/or improve overall incentives in the hospital rate system. It was clear to staff, that failure to identify initiatives of this nature would inevitably lead to more arbitrary (and possibly "capricious") cuts in Medicaid spending and eligibility. For the balance of this document the terms UC Fund and UC Pool are used interchangeably.

Pooling of Shock Trauma UC and 100% Pooling of Uncompensated Care

In response to the Secretary's request, the staff investigated the potential impact on Medicaid of : 1) including the University of Maryland Shock Trauma Center in the existing UC Pool (previously the Shock Trauma Center, which generates between 22 -24% uncompensated care annually was not included in the UC Pool); and 2) move the system to 100% pooling of all hospital UC.

When the existing UC Pool was first established in 1997, the staff was granted authority by the Commission to include Shock Trauma in the UC Pool. However, at the time, staff and the industry agreed it was not necessary to pool UC generated by the Shock Trauma Center because, as a State-wide resource, the care provide by Shock Trauma was relatively price-insensitive and not vulnerable to changes in market share due to any lack of competitiveness caused by high UC levels built into its rate structure. Given the existence of this authority however, following discussions with representatives of both the hospital and payer industries, staff decided to include the University of Maryland Shock Trauma Center UC in the existing UC pool for FY 2009 (retroactive to July 1, 2008). Because Medicaid accounts for approximately 25% of payments to Shock Trauma, a spreading of the Center's UC burden State-wide will result in a reduction overall payments by Medicaid and save the State approximately $3.5 million in total expenditures and $1.7 million in State general funds. This change will be accomplished with the issuance of FY 2009 rate orders in November of this year.

Additionally, the staff estimated that a move to 100% pooling of all Maryland hospital UC (including the pooling of Shock Trauma UC) would result in annual savings of about $10 million to Medicaid (or about $4.9 million in State General Funds).

Again, this savings results because Medicaid patients are concentrated at facilities that have higher overall levels of UC and thus higher rates due to their higher UC provisions. The 100% UC pooling proposal contemplates incorporating the State-wide average level of hospital UC into the rate structures of all facilities. Thus, after 100% pooling, hospitals treating higher proportions of the uninsured (and also higher proportions of Medicaid patients) will see their rates reduced and payers with a higher proportion of their patients being treated at these facilities will see reduced overall expenditures. Conversely, payers with patients concentrated at hospitals with previously lower UC provisions (relative to the State-wide) average will, under 100% pooling of hospital UC, see increased rate levels and will experience higher expenditures.

The staff believes this new system however is justified in that it fulfills the original intent of HB 924, namely implementation of the broadest and most equitable mechanism for financing the overall State burden of providing care to the uninsured. Table 2 below provides a simplified and illustrative example of a 100% UC pooling alternative.

Table 2
Example of Full Pooling

Annual Patient Revenue	$11.0 Billion
Annual Hospital UC	$770 million
State-wide Average UC	7.0%
Pre-determied UC Threshold	8.5%

		100% Pooling			
High UC Hospitals	Policy Determined UC Provisions (in rates)	UC Provision (in rates)	Pool Assessment	Total UC (in rates)	Payment from UC Pool
Hospital 1	15.0%	7.0%	NA	7.0%	8.0%
Hospital 2	12.0%	7.0%	NA	7.0%	5.0%
Hospital 3	10.0%	7.0%	NA	7.0%	3.0%
Hospital 4	9.0%	7.0%	NA	7.0%	2.0%
Hospital 5	8.0%	7.0%	NA	7.0%	1.0%

Low UC Hospitals	Policy Determined UC Provisions	UC Provision (in rates)		Total UC (in rates)	Remittance to UC Pool
Hospital 1	5.0%	7.0%	NA	7.0%	2.0%
Hospital 2	4.0%	7.0%	NA	7.0%	3.0%
Hospital 3	3.5%	7.0%	NA	7.0%	3.5%
Hospital 4	3.0%	7.0%	NA	7.0%	4.0%
Hospital 5	2.0%	7.0%	NA	7.0%	5.0%

Exhibits 1 and 2 to this recommendation provide more complete estimates of the impacts of a 100% pooling initiative for all Maryland hospitals.

Discussions with the Industry and Operational and Technical Considerations

As mentioned, in advance of this final recommendation the staff has discussed these two proposals (first pooling Shock Trauma UC retroactive to July 1, 2008 and full pooling of all hospital UC effective December 2008) with representatives of the hospital and payer industries. All representatives were generally supportive of these initiatives. The major concerns centered on the implementation and timing of the 100% Pooling proposal.

Timing of Full Pooling

Staff's intent is to implement 100% pooling effective December 2008 in order to capture some Medicaid savings in FY 2009. Savings from the initiation of full pooling will flow directly back to the Medicaid program for all "fee for service" Medicaid patients. To capture savings associated with payments to Medicaid Managed Care ("MCOs") patients, the Department will need to adjust Medicaid Managed Care Organization capitation rates commensurate with the anticipated change in hospital rates State-wide as a result of 100% pooling. Anticipated impacts by hospital can easily be provided to the Department to ensure appropriate MCO rate adjustments.

Additionally, in order to implement the full pooling December 2008, the HSCRC would need to authorize both an increase in all low UC hospital rates and a reduction of all high UC hospital rates effective December 1, 2008. Lower UC hospitals will require time to collect and accumulate revenues associated with their higher UC provisions (for approximately 30-60 days) prior to paying such accumulated surplus amounts into the broader State-wide pool. Owing to a current surplus in the existing UC pool staff has estimated that payments to high UC hospitals (in order to further reduce the magnitude of their UC in rate to State-wide levels) can commence December 2008. It is anticipated that additional funding (from low UC hospitals) will be available to permit continued operation of full pooling starting February 1, 2009. As articulated in the final regulations proposed November 5, 2008, the HSCRC would instruct the low UC hospitals to remit funds in excess of their approved UC provisions to the UC Fund on a monthly basis beginning in February.

Operational Considerations of Full Pooling

Full pooling of hospital UC is already authorized under the HSCRC's existing statute. To accomplish 100% pooling of hospital UC in Maryland, the Commission must issue regulations that enable HSCRC to make a special adjustment to UC provision of each hospital's "mark-up" (the mark-up between approved cost and final rates), to bring that mark-up to equal the average amount of State-wide uncompensated care. The Commission would notify each facility in writing of the amount due to be remitted from that hospital (if any) to the broader UC Fund or Pool. Conversely, hospitals which approved UC provisions in excess of the State-wide average level of UC would receive payment from the UC fund equal to the difference between their approved provisions and the State-wide average UC.

On or before the first business day of each month (beginning February 1, 2009), the HSCRC would direct the General Accounting Division to arrange for the collection of the amount due o be remitted by individual hospitals. This amount shall be based on the difference between a hospital's approved uncompensated care provision and the State-wide UC average.

Revenue Neutrality

It would be the intent of the Commission that the implementation of full UC pooling would be revenue neutral for all hospitals. That is, while some hospitals' rates will increase and some hospitals' rates will decrease as a result of 100% pooling, every hospital will continue to receive

the same net payment levels in the absence of this proposal.

The HSCRC will consult with representative of the hospital industry and the MHA's Technical Issues Task Force to ensure that hospitals do not experience net cash flow increases or reductions as a result of this initiative.

If necessary, a year-end reconciliation will be undertaken to ensure revenue and cash-flow neutrality for the FY 2009 and subsequent years.

Staff Recommendations

1. Implement 100% pooling of all approved levels of hospital uncompensated care effective December 2008[1]. This initiative will require that the Commission increase the UC mark-ups of low uncompensated care hospitals and decrease the markups of low uncompensated care hospitals effective in December 2008 in order to generate sufficient additional funding early in FY 2009 to finance additional pooled uncompensated care.

2. Beginning December 2008, the HSCRC will lower the mark-ups of high uncompensated care hospitals (hospitals with approved UC provisions based on the FY 2009 UC policy that are in excess of the State-wide average UC level).

3. Also beginning in December 2008 (and in each subsequent month), these high uncompensated care hospitals will receive a monthly proportion of the difference between the State-wide UC average and their approved UC provision directly from the UC Fund or Pool.

4. In January and subsequent months, the HSCRC staff will instruct the low UC hospitals (those with approved UC levels below the State-wide average) to remit (effective February1 and the first of all subsequent months) an amount that based on the difference between a hospitals' uncompensated care provision in its mark-up and the State-wide average UC.

5. The HSCRC staff will undertake all necessary calculations and work closely with the hospital and payer industries to ensure this proposal is revenue neutral and cash flow neutral for all hospitals (relative to what would have occurred in the absence of this initiative).

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[1] Note: The exact day of implementation is dependent on the date on which the Joint Committee on Administrative, Executive, and Legislative Review grants emergency status for the attached proposed regulations under COMAR 10.37.09 entitled Fee Assessment for Financing Hospital Uncompensated Care.

Appendix 1 – FY 2009 UC Policy Result

Uncompensated Care Policy Results for FY 2009

	Policy Results July 1, 2008	Markup	Adjustment to UCC % for Averted BD	In Rates AFTER July 1, 2008 Adjusted for Averted BD	Markup
WASHINGTON CO.	7.04%	1.126022	-0.37%	**6.67%**	**1.121443**
UNIVERSITY OF MD.	9.61%	1.159955	-0.92%	**8.69%**	**1.147950**
PRINCE GEORGE	13.91%	1.218358	-0.56%	**13.35%**	**1.210266**
HOLY CROSS	6.66%	1.114270	-0.23%	**6.43%**	**1.111479**
FREDERICK MEM.	5.82%	1.106239	-0.20%	**5.62%**	**1.103845**
HARFORD MEM.	8.58%	1.140519	-0.34%	**8.24%**	**1.136201**
ST. JOSEPH'S	2.90%	1.075303	-0.09%	**2.81%**	**1.074284**
MERCY	8.25%	1.137974	-0.46%	**7.79%**	**1.132166**
JOHNS HOPKINS	6.16%	1.109699	-0.51%	**5.65%**	**1.103578**
DORCHESTER GEN.	8.83%	1.152465	-0.58%	**8.25%**	**1.144965**
ST. AGNES	7.39%	1.132797	-0.32%	**7.07%**	**1.128787**
SINAI	7.52%	1.131441	-0.46%	**7.06%**	**1.125700**
BON SECOURS	14.33%	1.231351	**-0.27%**	**14.06%**	**1.231351**
FRANKLIN SQUARE	8.44%	1.144781	-0.51%	**7.93%**	**1.138268**
WASHINGTON ADV.	7.56%	1.133150	-0.27%	**7.29%**	**1.129762**
GARRETT CO.	8.79%	1.154621	-0.71%	**8.08%**	**1.145419**
MONTGOMERY GEN.	6.24%	1.114991	-0.21%	**6.03%**	**1.112439**
PENINSULA GEN.	5.84%	1.112759	-0.28%	**5.56%**	**1.109372**
SUBURBAN	4.81%	1.097153	-0.10%	**4.71%**	**1.095974**
ANNE ARUNDEL GEN.	4.49%	1.088280	-0.13%	**4.36%**	**1.086969**
UNION MEM.	6.66%	1.122744	-0.33%	**6.33%**	**1.118682**
MEM. CUMBERLAND	5.49%	1.107079	-0.63%	**4.86%**	**1.099563**
[C]RED HEART	4.29%	1.100299	-0.23%	**4.06%**	**1.097577**
[ ]MARY'S	6.87%	1.119329	-0.36%	**6.51%**	**1.114927**
BAYVIEW	9.04%	1.153680	-0.36%	**8.68%**	**1.149003**
CHESTER RIVER	7.86%	1.134281	-0.47%	**7.39%**	**1.128386**
UNION OF CECIL	8.02%	1.135078	-0.13%	**7.89%**	**1.133439**
CARROLL CO. GEN.	5.40%	1.104713	-0.23%	**5.17%**	**1.101969**
HARBOR HOSP.	9.57%	1.159666	-0.52%	**9.05%**	**1.152853**
CIVISTA	6.41%	1.116276	-0.31%	**6.10%**	**1.112503**
MEM. EASTON	6.39%	1.121774	-0.47%	**5.92%**	**1.116008**
MARYLAND GEN.	12.00%	1.201688	-0.41%	**11.59%**	**1.195914**
CALVERT MEMORIAL	6.35%	1.113469	-0.21%	**6.14%**	**1.110924**
NORTHWEST	7.52%	1.133318	-0.22%	**7.30%**	**1.130556**
BALTIMORE/WASHINC	6.96%	1.120479	-0.23%	**6.73%**	**1.117656**
G.B.M.C.	2.64%	1.067284	-0.10%	**2.54%**	**1.066169**
MCCREADY	8.51%	1.151359	-1.67%	**6.84%**	**1.130065**
HOWARD CO. GEN.	6.05%	1.105576	-0.32%	**5.73%**	**1.101756**
UPPER CHESAPEAKE	5.69%	1.104440	-0.22%	**5.47%**	**1.101816**
DR'S COMMUNITY HO[S	8.56%	1.141869	-0.31%	**8.25%**	**1.137922**
SOUTHERN MD.	7.59%	1.131195	-0.20%	**7.39%**	**1.128966**
LAUREL REGIONAL	11.34%	1.178099	-0.27%	**11.07%**	**1.174438**
FORT WASHINGTON	10.24%	1.161470	-0.64%	**9.60%**	**1.153070**
ATLANTIC GENERAL	6.10%	1.114652	-0.46%	**5.64%**	**1.109079**
KERNANS	6.04%	1.113214	-0.16%	**5.88%**	**1.111274**
GOOD SAMARITAN	6.01%	1.118159	-0.29%	**5.72%**	**1.114617**
S[ ]DY GROVE	6.91%	1.117712	-0.31%	**6.60%**	**1.113929**
[ ]OCK TRAUMA	21.08%	1.320081	0.00%	**21.08%**	**1.320081**
CANCER CENTER	9.28%	1.148232	0.00%	**9.28%**	**1.148232**
State-wide Total	7.35%	1.133182	-0.41%	**6.97%**	**1.119121**
				-0.38%	

Appendix 2a and 2b – Medicaid Impact of Pooling Shock Trauma and Incremental Impact to Medicaid of Full Pooling

Projected Medicaid Savings for Inclusion of Shock Tra[illegible] Center

Increased Payouts from 85,524,661 to 92,064,240 6,539,5[illegible] INCREASE
Re-establishes Limit at 7.15% (currently 6.85%)

	Gross Rev Before Redistribution	Gross Rev After Redistribution	Difference	Current Gross Rev After Redistribution	Difference	FSS Medicaid Percent	Total Medicaid Savings	**State Medicaid Savings**	Medicare Percent FY 2007	Gross Medicare Difference	Current Medicare Gross Revenue	Impact on Medicare
WASHINGTON CO.	232,488,641	232,488,641	0	232,488,641	(0)	2.61%	(0)	(0)	46.52%	108,163,816	(0)	
UNIVERSITY OF MD.	912,647,899	897,058,647	(15,589,251)	894,092,653	2,965,995	11.64%	345,365	**162,322**	28.43%	254,234,192	843,377	
PRINCE GEORGE	270,211,425	251,699,876	(18,511,548)	250,868,394	831,483	16.50%	137,159	**64,465**	28.48%	71,459,857	236,848	
HOLY CROSS	388,096,704	388,096,704	0	388,096,704	0	8.35%	0	**0**	28.83%	111,897,960	0	
FREDERICK MEM.	253,136,956	253,136,956	0	253,136,956	0	2.71%	0	**0**	38.49%	97,432,674	0	
HARFORD MEM.	90,235,256	89,155,124	(1,080,132)	88,861,840	293,284	2.20%	6,455	**3,034**	40.10%	35,629,549	117,593	
ST. JOSEPH'S	371,701,703	371,701,703	0	371,701,703	0	1.60%	0	**0**	47.10%	175,056,533	0	
MERCY	360,872,199	358,318,897	(2,553,302)	357,138,548	1,180,349	5.06%	59,699	**28,058**	31.53%	112,620,130	372,211	
JOHNS HOPKINS	1,546,567,464	1,546,567,464	0	1,546,567,464	0	6.03%	0	**0**	26.78%	414,129,714	0	
DORCHESTER GEN.	50,830,441	50,210,671	(619,770)	50,044,266	166,405	5.57%	9,276	**4,360**	48.32%	24,180,382	80,403	
ST. AGNES	343,444,838	343,444,838	0	342,599,188	845,650	5.47%	46,234	**21,730**	41.58%	142,467,833	351,659	
SINAI	613,959,687	613,959,687	0	612,538,610	1,421,076	6.60%	93,728	**44,052**	37.38%	228,983,911	531,238	
BON SECOURS	113,588,434	104,845,895	(8,742,539)	104,496,715	349,180	10.85%	37,871	**17,800**	41.79%	43,668,389	145,920	
FRANKLIN SQUARE	408,168,048	404,648,903	(3,519,145)	403,310,856	1,338,046	6.93%	92,765	**43,599**	38.68%	156,005,625	517,573	
WASHINGTON ADV.	277,843,776	277,415,719	(428,057)	276,498,743	916,976	7.30%	66,910	**31,448**	42.33%	117,028,797	388,112	
GARRETT CO.	35,763,942	35,394,447	(369,495)	35,276,878	117,569	13.77%	16,193	**7,611**	46.03%	16,239,634	54,122	
MONTGOMERY GEN.	134,981,914	134,981,914	0	134,981,914	(0)	1.40%	(0)	(0)	49.41%	66,701,013	(0)	
PENINSULA GEN.	367,879,062	367,879,062	0	367,879,062	(0)	1.45%	(0)	(0)	51.21%	188,385,369	(0)	
SUBURBAN	224,435,792	224,435,792	0	224,435,792	0	1.11%	0	0	49.15%	110,304,006	0	
ANNE ARUNDEL GEN.	359,860,248	359,860,248	0	359,860,248	0	1.90%	0	0	34.86%	125,463,792	0	
UNION MEM.	410,945,032	410,945,032	0	410,945,032	0	5.93%	0	0	43.79%	179,960,353	0	
MEM. CUMBERLAND	104,232,998	104,232,998	(0)	104,232,998	(0)	3.39%	(0)	(0)	43.24%	45,071,344	(0)	
SACRED HEART	156,110,810	156,110,810	(0)	156,110,810	0	5.66%	0	0	56.25%	87,813,316	0	
ST. MARY'S	117,748,883	117,748,883	0	117,748,883	0	2.19%	0	0	37.04%	43,613,893	0	
BAYVIEW	513,913,805	505,234,238	(8,679,567)	503,561,900	1,672,337	10.92%	182,630	**85,836**	33.68%	169,623,279	563,322	
CHESTER RIVER	61,554,840	61,394,279	(160,561)	61,191,808	202,472	1.46%	2,959	**1,391**	45.55%	27,871,096	92,220	
UNION OF CECIL	118,850,110	117,881,162	(968,948)	117,492,831	388,331	3.78%	14,666	**6,893**	38.90%	45,704,718	151,061	
CARROLL CO. GEN.	185,096,327	185,096,327	0	185,096,327	(0)	6.52%	(0)	(0)	44.10%	81,621,985	(0)	
HARBOR HOSP.	199,854,715	195,657,831	(4,196,883)	195,010,745	647,087	5.07%	32,805	**15,418**	36.93%	72,021,068	238,981	
DIVISTA	100,839,708	100,839,708	(0)	100,839,708	0	2.76%	0	0	42.83%	43,185,815	0	
MEM. EASTON	147,386,652	147,386,652	0	147,386,652	(0)	3.30%	(0)	(0)	51.26%	75,551,747	(0)	
MARYLAND GEN.	198,037,456	188,249,230	(9,788,225)	187,622,159	627,072	14.68%	92,068	**43,272**	34.16%	64,089,764	214,201	
CALVERT MEMORIAL	104,208,515	104,208,515	0	104,208,515	(0)	3.51%	(0)	(0)	38.12%	39,725,522	(0)	
NORTHWEST	211,970,567	211,608,438	(362,130)	210,908,610	699,827	4.76%	33,287	**15,645**	48.16%	101,563,151	337,002	
BALTIMORE/WASHING	292,923,445	292,923,445	0	292,923,445	(0)	1.04%	(0)	(0)	42.93%	125,739,003	(0)	
C.B.M.C.	369,778,002	369,778,002	0	369,778,002	0	1.50%	0	0	36.27%	134,130,123	0	
ACCREADY	17,261,804	17,261,804	0	17,261,804	(0)	1.50%	(0)	(0)	44.61%	7,700,735	(0)	
HOWARD CO. GEN.	208,931,226	208,931,226	(0)	208,931,226	(0)	2.85%	(0)	(0)	33.14%	69,234,387	(0)	
UPPER CHESAPEAKE	184,359,753	184,359,753	0	184,359,753	(0)	0.84%	(0)	(0)	38.94%	71,792,674	(0)	
ER'S COMMUNITY HO[illegible]	184,961,185	182,712,733	(2,248,452)	182,110,889	601,844	3.95%	23,752	**11,164**	41.26%	75,135,642	248,310	
SOUTHERN MD.	229,634,034	229,035,053	(598,981)	228,279,334	755,719	3.90%	29,468	**13,850**	38.80%	88,576,538	293,233	
LAUREL REGIONAL	100,373,201	96,042,384	(4,330,817)	95,726,118	316,266	5.79%	18,298	**8,600**	37.22%	35,631,377	117,721	
PORT WASHINGTON	48,050,781	46,756,430	(1,294,351)	46,602,701	153,729	3.55%	5,457	**2,565**	36.30%	16,918,536	55,809	
ATLANTIC GENERAL	73,192,673	73,192,673	0	73,192,673	0	0.61%	0	0	52.01%	38,064,146	0	
TERNANS	101,113,255	101,113,255	0	101,113,255	(0)	15.31%	(0)	(0)	30.75%	31,090,568	(0)	
GOOD SAMARITAN	264,716,683	264,716,683	0	264,716,683	(0)	4.84%	(0)	(0)	52.97%	140,228,717	(0)	
LADY GROVE	297,576,202	297,576,202	0	297,576,202	(0)	4.95%	(0)	(0)	30.56%	90,929,903	(0)	
SHOCK TRAUMA	177,533,883	150,425,735	(27,108,147)	177,533,883	(27,108,147)	20.53%	(5,564,935)	**(2,615,520)**	12.11%	21,500,938	(3,283,039)	
CANCER CENTER	61,335,534	61,335,534	0	61,335,534	(0)	9.49%	(0)	(0)	29.17%	17,890,704	(0)	
			0									
	12,598,688,016	12,498,673,653	(100,014,363)	12,488,056,202	(10,617,451)		(4,217,890)	**(1,982,409)**	37.17%	4,642,034,215	2,667,878	0.06%

Projected Medicaid Incremental Savings for Full Pooling

Removes 0.75% UCC Fund Payment
Dedistributes UCC Evenly Across All Hospitals

	Gross Rev Before Redistribution	Gross Rev After Removal of UCC Payment 75% Assessment	Gross Rev After Redistribution	Difference	Current Gross Rev After UCC Fund Redistribution	Difference	Medicaid Percent FY 2007	Gross Medicaid Savings	**Net State Medicaid Savings**	Medicare Percent FY 2007	Gross Medicare Difference	Current Medicare Gross Revenue	
WASHINGTON CO.	$232,488,641	230,744,976	231,347,324	602,347	232,488,641	(1,141,317)	10.59%	(120,901)	**(56,823)**	46.52%	(530,990)	108,163,816	
UNIVERSITY OF MD.	$912,647,899	905,803,040	887,971,412	(17,831,628)	897,058,647	(9,087,235)	29.96%	(2,722,466)	**(1,279,559)**	28.43%	(2,583,945)	255,077,569	
PRINCE GEORGE	$270,211,425	268,184,839	249,150,726	(19,034,113)	251,699,876	(2,549,150)	28.36%	(722,933)	**(339,779)**	28.48%	(726,125)	71,696,704	
HOLY CROSS	$388,096,704	385,185,979	387,230,193	2,044,214	388,096,704	(866,511)	14.25%	(123,513)	**(58,051)**	28.83%	(249,837)	111,897,960	
FREDERICK MEM.	$253,136,956	251,238,428	254,787,934	3,549,506	253,136,956	1,650,978	7.92%	130,815	**61,483**	38.49%	635,463	97,432,674	
HARFORD MEM.	$90,235,256	89,558,491	88,253,169	(1,305,322)	89,155,124	(901,955)	6.83%	(61,644)	**(28,973)**	40.10%	(361,643)	35,747,142	
ST. JOSEPH'S	$371,701,703	368,913,940	385,544,835	16,630,895	371,701,703	13,843,132	5.97%	826,259	**388,342**	47.10%	6,519,558	175,056,533	
MERCY	$360,872,199	358,165,658	354,692,601	(3,473,057)	358,318,897	(3,626,296)	18.05%	(654,411)	**(307,573)**	31.53%	(1,143,517)	112,992,342	
JOHNS HOPKINS	$1,546,567,464	1,534,968,208	1,556,099,433	21,131,225	1,546,567,464	9,531,969	18.26%	1,740,094	**817,844**	26.78%	2,552,408	414,129,714	
DORCHESTER GEN.	$50,830,441	50,449,213	49,701,724	(747,489)	50,210,671	(508,947)	14.43%	(73,463)	**(34,528)**	48.32%	(245,913)	24,260,786	
ST. AGNES	$343,444,838	340,869,002	340,253,924	(615,078)	343,444,838	(3,190,914)	18.87%	(602,134)	**(283,003)**	41.58%	(1,326,923)	142,819,491	
SINAI	$613,959,687	609,354,989	608,344,437	(1,010,552)	613,959,687	(5,615,249)	18.19%	(1,021,430)	**(480,072)**	37.38%	(2,099,136)	229,515,149	
BON SECOURS	$113,069,946	112,221,921	103,781,795	(8,440,126)	104,845,895	(1,064,100)	32.29%	(343,615)	**(161,499)**	41.79%	(444,679)	43,814,308	
FRANKLIN SQUARE	$408,168,048	405,106,788	400,549,689	(4,557,099)	404,648,903	(4,099,214)	20.07%	(822,697)	**(386,668)**	38.68%	(1,585,626)	156,523,198	
WASHINGTON ADV.	$277,843,776	275,759,947	274,605,694	(1,154,253)	277,415,719	(2,810,025)	14.85%	(417,370)	**(196,164)**	42.33%	(1,189,350)	117,416,910	
GARRETT CO.	$35,763,942	35,495,712	35,035,468	(460,244)	35,394,447	(358,978)	22.51%	(80,819)	**(37,985)**	46.03%	(165,255)	16,293,757	
MONTGOMERY GEN.	$134,981,914	133,969,550	135,259,558	1,290,009	134,981,914	277,644	4.97%	13,799	**6,485**	49.41%	137,197	66,701,013	
PENINSULA GEN.	$367,879,062	365,119,969	370,553,916	5,433,947	367,879,062	2,674,854	8.80%	235,453	**110,663**	51.21%	1,369,753	188,385,369	
SUBURBAN	$224,435,792	222,752,524	228,153,719	5,401,195	224,435,792	3,717,926	3.04%	112,876	**53,052**	49.15%	1,827,258	110,304,006	
ANNE ARUNDEL GEN.	$359,860,248	357,161,297	367,113,228	9,951,931	359,860,248	7,252,979	6.62%	480,282	**225,732**	34.86%	2,528,721	125,463,792	
UNION MEM.	$410,945,032	407,862,945	410,457,458	2,594,513	410,945,032	(487,574)	15.42%	(75,165)	**(35,328)**	43.79%	(213,518)	179,960,353	
MEM. CUMBERLAND	$104,232,998	103,451,250	105,789,565	2,338,315	104,232,998	1,556,567	13.42%	208,900	**98,183**	43.24%	673,075	45,071,344	
SACRED HEART	$156,110,810	154,939,978	159,840,276	4,900,298	156,110,810	3,729,467	15.78%	588,366	**276,532**	56.25%	2,097,849	87,813,316	
ST. MARY'S	$117,748,883	116,865,766	117,377,513	511,747	117,748,883	(371,370)	10.11%	(37,539)	**(17,643)**	37.04%	(137,554)	43,613,893	
BAYVIEW	$513,913,805	510,059,451	500,114,722	(9,944,729)	505,234,238	(5,119,516)	27.29%	(1,396,955)	**(656,569)**	33.68%	(1,724,493)	170,186,601	
CHESTER RIVER	$61,554,840	61,093,179	60,772,767	(320,412)	61,394,279	(621,512)	7.70%	(47,826)	**(22,478)**	45.55%	(283,081)	27,963,316	
UNION OF CECIL	$118,850,110	117,958,734	116,688,157	(1,270,577)	117,881,162	(1,193,005)	11.56%	(137,963)	**(64,843)**	38.90%	(464,079)	45,855,779	
CARROLL CO. GEN.	$185,096,327	183,708,104	187,235,406	3,527,302	185,096,327	2,139,079	8.92%	190,814	**89,683**	44.10%	943,270	81,621,985	
HARBOR HOSP.	$199,854,715	198,355,804	193,675,674	(4,680,131)	195,657,831	(1,982,158)	22.04%	(436,941)	**(205,362)**	36.93%	(732,047)	72,260,049	
CIVISTA	$100,839,708	100,083,410	100,969,985	886,575	100,839,708	130,277	9.39%	12,228	**5,747**	42.83%	55,793	43,185,815	
MEM. EASTON	$147,386,652	146,281,252	147,882,666	1,601,414	147,386,652	496,014	11.71%	58,075	**27,295**	51.26%	254,261	75,551,747	
MARYLAND GEN.	$198,037,456	196,552,175	186,338,556	(10,213,619)	188,249,230	(1,910,675)	41.32%	(789,402)	**(371,019)**	34.16%	(652,666)	64,303,965	
CALVERT MEMORIAL	$104,208,515	103,426,951	104,306,234	879,283	104,208,515	97,719	10.52%	10,283	**4,833**	38.12%	37,252	39,725,522	
NORTHWEST	$211,970,567	210,380,788	209,464,698	(916,090)	211,608,438	(2,143,740)	11.23%	(240,800)	**(113,176)**	48.16%	(1,032,319)	101,900,153	
BALTIMORE/WASHING	$292,923,445	290,726,519	291,297,366	570,847	292,923,445	(1,626,078)	4.49%	(72,931)	**(34,277)**	42.93%	(698,003)	125,739,003	
G.B.M.C.	$369,778,002	367,004,667	384,562,579	17,557,912	369,778,002	14,784,577	5.07%	749,156	**352,103**	36.27%	5,362,832	134,130,123	
MCCREADY	$17,261,804	17,132,341	17,144,810	12,469	17,261,804	(116,994)	24.29%	(28,421)	**(13,358)**	44.61%	(52,193)	7,700,735	
HOWARD CO. GEN.	$208,931,226	207,364,241	210,037,507	2,673,266	208,931,226	1,106,281	6.60%	73,029	**34,324**	33.14%	366,593	69,234,387	
UPPER CHESAPEAKE	$184,359,753	182,977,055	185,861,001	2,883,946	184,359,753	1,501,248	6.87%	103,092	**48,453**	38.94%	584,610	71,792,674	
DR'S COMMUNITY HO:	$184,961,185	183,573,976	180,863,653	(2,710,323)	182,712,733	(1,849,080)	8.92%	(164,873)	**(77,490)**	41.26%	(762,897)	75,383,952	
SOUTHERN MD.	$229,634,034	227,911,779	226,716,155	(1,195,623)	229,035,053	(2,318,898)	14.51%	(336,361)	**(158,089)**	38.80%	(899,775)	88,869,770	
LAUREL REGIONAL	$100,373,201	99,620,402	95,070,493	(4,549,908)	96,042,384	(971,891)	12.40%	(120,510)	**(56,640)**	37.22%	(361,759)	35,749,098	
FORT WASHINGTON	$48,050,781	47,690,400	46,283,474	(1,406,926)	46,756,430	(472,956)	9.39%	(44,418)	**(20,876)**	36.30%	(171,701)	16,974,345	
ATLANTIC GENERAL	$73,192,673	72,643,728	73,657,678	1,013,951	73,192,673	465,006	4.55%	21,143	**9,937**	52.01%	241,828	38,064,146	
KERNANS	$101,113,255	100,354,905	101,492,897	1,137,991	101,113,255	379,642	24.71%	93,825	**44,098**	30.75%	116,733	31,090,568	
GOOD SAMARITAN	$264,716,683	262,731,308	266,202,374	3,471,066	264,716,683	1,485,691	13.22%	196,341	**92,280**	52.97%	787,017	140,228,717	
SHADY GROVE	$297,576,202	295,344,380	296,348,467	1,004,086	297,576,202	(1,227,735)	12.08%	(148,254)	**(69,679)**	30.56%	(375,157)	90,929,903	
SHOCK TRAUMA	$177,533,883	176,202,378	148,905,354	(27,297,025)	150,425,735	(1,520,381)	26 79%	(407,240)	**(191,403)**	12.11%	(184,132)	18,217,900	
CANCER CENTER	$61,335,534	60,875,517	59,294,028	(1,581,490)	61,335,534	(2,041,506)	15.45%	(315,502)	**(148,286)**	29.17%	(595,478)	17,890,704	
	12,598,688,016	12,504,197,856	12,493,082,292	(11,115,564)	12,488,056,202	(5,026,089)		(6,723,670)	**(3,160,125)**	37.19%	5,097,679	4,644,702,094	0.11%

Appendix 3 – Estimated Payments into and out of the UC Fund (Full Pooling)

Calculation of Payments To and From Fund

Based on Full Pooling of UCC

July 1, 2008 to June 30, 2009

	July 1, 2008 REVENUE ADJ. FOR NEW MU	July 1, 2008 REVENUE After .75% Removed	NEW MARK UP FROM ALGORITHM	NET REVENUE	POLICY FINAL RESULT 7/01/08	NEW $ AMOUNT UCC COST	NEW UCC MAXIMUM RATE 6.9700%	PERCENT DIFFERENCE	NEW APPROVED MARK UP (INCL MAX)	GROSS REVENUE AT NEW UCC $0	COLLECTED NET REV. AT NEW UCC	PAYMENT FROM (TO) HOSPITALS	OVERAGE PAYMENT FROM HOSPITALS	SHORTAGE-PAYMENT (TO) HOSPITALS
	Q		W	X	Y	Z	AA	AB	AC	AD	AE	AF	AI	AJ
WASHINGTON CO.	232,488,641	$230,744,976	1.121443	205,757,215	6.67%	13,729,794	6.91%	0.24%	1.124370	231,347,324	206,294,333	537,118	537,118	0
UNIVERSITY OF MD.	912,647,899	$905,803,040	1.147950	789,061,470	8.69%	68,606,844	6.91%	-1.79%	1.125351	887,971,412	773,528,015	(15,533,454)	0	(15,533,454)
PRINCE GEORGE	270,211,425	$268,184,839	1.210266	221,591,731	13.35%	29,584,436	6.91%	-6.44%	1.124368	249,150,726	205,864,511	(15,727,220)	0	(15,727,220)
HOLY CROSS	388,096,704	$385,185,979	1.111479	346,552,752	6.43%	22,266,252	6.91%	0.48%	1.117377	387,230,193	348,391,937	1,839,184	1,839,184	0
FREDERICK MEM.	253,136,956	$251,238,428	1.103845	227,602,920	5.62%	12,795,613	6.91%	1.29%	1.119441	254,787,934	230,818,502	3,215,582	3,215,582	0
HARFORD MEM.	90,235,256	$89,558,491	1.136201	78,822,771	8.24%	6,493,460	6.91%	-1.33%	1.119641	88,253,169	77,673,924	(1,148,848)	0	(1,148,848)
ST. JOSEPH'S	371,701,703	$368,913,940	1.074284	343,404,534	2.81%	9,658,049	6.91%	4.10%	1.122713	385,544,835	358,885,447	15,480,913	15,480,913	0
MERCY	360,872,199	$358,165,658	1.132166	316,354,358	7.79%	24,651,086	6.91%	-0.88%	1.121188	354,692,601	313,286,736	(3,067,622)	0	(3,067,622)
JOHNS HOPKINS	1,546,567,464	$1,534,968,208	1.103578	1,390,901,674	5.65%	78,642,975	6.91%	1.26%	1.118770	1,556,099,433	1,410,049,599	19,147,925	19,147,925	0
DORCHESTER GEN.	50,830,441	$50,449,213	1.144965	44,061,814	8.25%	3,635,126	6.91%	-1.34%	1.128000	49,701,724	43,408,965	(652,849)	0	(652,849)
ST. AGNES	343,444,838	$340,869,002	1.128787	301,978,096	7.07%	21,359,316	6.91%	-0.16%	1.126750	340,253,924	301,433,195	(544,901)	0	(544,901)
SINAI	613,959,687	$609,354,989	1.125700	541,312,201	7.06%	38,218,255	6.91%	-0.15%	1.123833	608,344,437	540,414,491	(897,710)	0	(897,710)
BON SECOURS	113,069,946	$112,221,921	1.225731	91,555,112	13.68%	12,524,739	6.91%	-6.77%	1.133545	103,781,795	84,669,321	(6,885,791)	0	(6,885,791)
FRANKLIN SQUARE	408,168,048	$405,106,788	1.138268	355,897,506	7.93%	28,221,353	6.91%	-1.02%	1.125464	400,549,689	351,893,969	(4,003,537)	0	(4,003,537)
WASHINGTON ADV.	277,843,776	$275,759,947	1.129762	244,086,688	7.29%	17,792,372	6.91%	-0.38%	1.125033	274,605,694	243,065,010	(1,021,678)	0	(1,021,678)
GARRETT CO.	35,763,942	$35,495,712	1.145419	30,989,288	8.08%	2,503,934	6.91%	-1.17%	1.130567	35,035,468	30,587,475	(401,813)	0	(401,813)
MONTGOMERY GEN.	134,981,914	$133,969,550	1.112439	120,428,716	6.03%	7,267,744	6.91%	0.87%	1.123150	135,259,558	121,588,338	1,159,622	1,159,622	0
PENINSULA GEN.	367,879,062	$365,119,969	1.109372	329,123,198	5.56%	18,302,143	6.91%	1.35%	1.125882	370,553,916	334,021,418	4,898,221	4,898,221	0
SUBURBAN	224,435,792	$222,752,524	1.095974	203,246,148	4.71%	9,563,945	6.91%	2.20%	1.122549	228,153,719	208,174,362	4,928,214	4,928,214	0
ANNE ARUNDEL GEN.	359,860,248	$357,161,297	1.086969	328,584,721	4.36%	15,589,585	6.91%	2.54%	1.117256	367,113,228	337,740,396	9,155,674	9,155,674	0
UNION MEM.	410,945,032	$407,862,945	1.118682	364,592,253	6.33%	23,090,162	6.91%	0.58%	1.125799	410,457,458	366,911,512	2,319,258	2,319,258	0
MEM. CUMBERLAND	104,232,998	$103,451,250	1.099563	94,083,956	4.86%	4,571,062	6.91%	2.05%	1.124417	105,789,565	96,210,541	2,126,585	2,126,585	0
SACRED HEART	156,110,810	$154,939,978	1.097577	141,165,433	4.06%	5,730,642	6.91%	2.85%	1.132290	159,840,276	145,630,083	4,464,649	4,464,649	0
ST. MARY'S	117,748,883	$116,865,766	1.114927	104,819,248	6.51%	6,824,464	6.91%	0.40%	1.119809	117,377,513	105,278,244	458,996	458,996	0
BAYVIEW	513,913,805	$510,059,451	1.149003	443,914,745	8.68%	44,251,028	6.91%	-1.77%	1.126601	500,114,722	435,259,652	(8,655,093)	0	(8,655,093)
CHESTER RIVER	61,554,840	$61,093,179	1.128386	54,142,101	7.39%	3,999,206	6.91%	-0.48%	1.122468	60,772,767	53,858,145	(283,956)	0	(283,956)
UNION OF CECIL	118,850,110	$117,958,734	1.133439	104,071,514	7.89%	8,211,242	6.91%	-0.98%	1.121231	116,688,157	102,950,522	(1,120,993)	0	(1,120,993)
CARROLL CO. GEN.	185,096,327	$183,708,104	1.101969	166,708,953	5.17%	8,610,964	6.91%	1.74%	1.123127	187,235,406	169,909,861	3,200,908	3,200,908	0
HARBOR HOSP.	199,854,715	$198,355,804	1.152853	172,056,512	9.05%	15,568,678	6.91%	-2.14%	1.125652	193,675,674	167,996,903	(4,059,609)	0	(4,059,609)
CIVISTA	100,839,708	$100,083,410	1.112503	89,962,335	6.10%	5,491,616	6.91%	0.81%	1.122358	100,969,985	90,759,254	796,919	796,919	0
MEM. EASTON	147,386,652	$146,281,252	1.116008	131,075,492	5.92%	7,759,130	6.91%	0.99%	1.128225	147,882,666	132,510,441	1,434,949	1,434,949	0
MARYLAND GEN.	198,037,456	$196,552,175	1.195914	164,353,158	11.59%	19,042,852	6.91%	-4.68%	1.133769	186,338,556	155,812,725	(8,540,432)	0	(8,540,432)
CALVERT MEMORIAL	104,208,515	$103,426,951	1.110924	93,099,961	6.14%	5,712,076	6.91%	0.77%	1.120368	104,306,234	93,891,449	791,488	791,488	0
NORTHWEST	211,970,567	$210,380,788	1.130556	186,086,198	7.30%	13,592,590	6.91%	-0.39%	1.125633	209,464,698	185,275,897	(810,301)	0	(810,301)
BALTIMORE/WASHING	292,923,445	$290,726,519	1.117656	260,121,680	6.73%	17,508,282	6.91%	0.18%	1.119850	291,297,366	260,632,434	510,754	510,754	0
G.B.M.C.	369,778,002	$367,004,667	1.066169	344,227,424	2.54%	8,743,377	6.91%	4.37%	1.117176	384,562,579	360,695,648	16,468,224	16,468,224	0
MCCREADY	17,261,804	$17,132,341	1.130065	15,160,485	6.84%	1,037,591	6.91%	0.07%	1.130888	17,144,810	15,171,519	11,034	11,034	0
HOWARD CO. GEN.	208,931,226	$207,364,241	1.101756	188,212,514	5.73%	10,786,342	6.91%	1.18%	1.115959	210,037,507	190,638,882	2,426,368	2,426,368	0
UPPER CHESAPEAKE	184,359,753	$182,977,055	1.101816	166,068,546	5.47%	9,088,430	6.91%	1.44%	1.119182	185,861,001	168,685,992	2,617,447	2,617,447	0
DR'S COMMUNITY HO	184,961,185	$183,573,976	1.137922	161,323,891	8.25%	13,314,884	6.91%	-1.34%	1.121121	180,863,653	158,942,073	(2,381,819)	0	(2,381,819)
SOUTHERN MD.	229,634,034	$227,911,779	1.128966	201,876,542	7.39%	14,911,361	6.91%	-0.48%	1.123044	226,716,155	200,817,499	(1,059,042)	0	(1,059,042)
LAUREL REGIONAL	100,373,201	$99,620,402	1.174438	84,823,898	11.07%	9,388,204	6.91%	-4.16%	1.120798	95,070,493	80,949,783	(3,874,116)	0	(3,874,116)
FORT WASHINGTON	48,050,781	$47,690,400	1.153070	41,359,488	9.60%	3,970,424	6.91%	-2.69%	1.119053	46,283,474	40,139,332	(1,220,156)	0	(1,220,156)
ATLANTIC GENERAL	73,192,673	$72,643,728	1.109079	65,499,138	5.64%	3,696,251	6.91%	1.27%	1.124560	73,657,678	66,413,366	914,227	914,227	0
CERNANS	101,113,255	$100,354,905	1.111274	90,306,138	5.88%	5,310,137	6.91%	1.03%	1.123876	101,492,897	91,330,180	1,024,041	1,024,041	0
GOOD SAMARITAN	264,716,683	$262,731,308	1.114617	235,714,369	5.72%	13,473,456	6.91%	1.19%	1.129343	266,202,374	238,828,502	3,114,133	3,114,133	0
SHADY GROVE	297,576,202	$295,344,380	1.113929	265,137,482	6.60%	17,497,342	6.91%	0.31%	1.117716	296,348,467	266,038,874	901,391	901,391	0
SHOCK TRAUMA	177,533,883	$176,202,378	1.320081	133,478,483	21.08%	28,137,264	6.91%	-14.17%	1.115576	148,905,354	112,800,184	(20,678,299)	0	(20,678,299)
CANCER CENTER	61,335,534	$60,875,517	1.148232	53,016,718	9.28%	4,919,951	6.91%	-2.37%	1.118402	59,294,028	51,639,393	(1,377,326)	0	(1,377,326)
	12,598,688,016	12,504,197,856	1.123692895	11,127,771,573	6.97%	775,646,032	6.97%	-0.00%	1.122694	12,493,082,292	11,127,768,835	(2,738)	103,943,826	(103,946,564)

Appendix 4 – Proposed Regulation

Title 10 DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Subtitle 37 HEALTH SERVICES COST REVIEW COMMISSION

Chapter 09 Fee Assessment for Financing Hospital Uncompensated Care

Authority: Health-General Article, §19-207; 19-213; and 19-214, Annotated Code of Maryland

.01 Definitions

A. In this chapter, the following terms have the meanings indicated:

B. Terms Defined.

[(1) "Assessment" means the dollar amount that the Health Services Cost Review Commission directs be collected from hospitals for a given month to finance the reasonable total costs of hospital uncompensated care and to reduce uncompensated care.]

[(2)] (1) "Automated clearing house (ACH)", as defined in COMAR 03.01.02.01B, means a central clearing organization that operates as a clearing house for transmitting or receiving entries between banks and bank accounts, and authorizes an electronic transfer of funds between banks or bank accounts.

[(3)] (2) "Commission" means the Health Services Cost Review Commission.

[(4)] (3) "Comptroller" means the Comptroller of the Treasury or the Comptroller's designee.

[(5)] (4) ["Fee"] "Remittance" means the amount each hospital remits to the General Accounting Division pursuant to the predetermined formula established by the Commission to provide funding for the Commission's Uncompensated Care Fund.

[(6)] (5) "General Accounting Division" means the Fiscal Services Administration for the Department of Health and Mental Hygiene.

(7) - (11) Repealed

[12)] (7) "Health Services Cost Review Commission Fund" means the special fund established under Health-General Article, §19-213 (d), Annotated Code of

Maryland.

[(13)] (8) "Hospital" means an institution that is licensed by the Department of Health and Mental Hygiene as an acute general hospital.

[(14)] (9) "Hospital Uncompensated Care Fund" means the monies that are collected from hospitals for the equitable financing of hospital uncompensated care and which are a discrete part of the Health Services Cost Review Commission Fund.

[(15)] (10) "Interest" means the investment earnings generated from the investment and reinvestment of the monies of the Hospital Uncompensated Care Fund which are separately held by the Treasury, accounted for by the Comptroller, and retained to the credit of the Health Services Cost Review Commission Fund.

(11) "Mark-up" means the mechanism used to increase hospital rates to allow for payer differentials, working capital (prompt payment) differentials, and a provision for uncompensated care.

[(16) "Request for proposals" means the documents used for soliciting proposals from hospitals for hospital sponsored programs that have the potential for reducing hospital uncompensated care.]

(12) "Special Rate Adjustment" means an adjustment to a hospital's rates, which will bring the hospital's uncompensated care provision of its mark-up to the statewide uncompensated care average.

[(17)] (13) "Treasury" means the State Treasury.

(18) - (19) Repealed

[(20)] (14) "Wire transfer" means an electronic transaction in which a hospital through the hospital's bank and an automated clearing house, or suitable alternative, originates an entry crediting the Health Services Cost Review Commission Fund's bank account and debiting the hospital's bank account on the same day the transaction is initiated.

.02 [Method of Fee Assessment and Collection.] Special Rate Adjustment and Collection.

A. The Commission shall [assess a fee on all acute general hospitals] make a special rate adjustment to the uncompensated care provision of each hospital's mark-up to pay for the financing of the reasonable costs of hospital uncompensated care. The Commission shall notify [each hospital] hospitals in writing of the amount [of the fee to be assessed] due to be remitted in a given month before the first day of that month.

B. On or before the first business day of each month, the Commission shall direct the General Accounting Division to arrange for the collection of [a monthly fee not to exceed 1.25% of the total gross operating revenue from each hospital whose rates have been approved by the Commission.] the amount due to be remitted by individual hospitals. This amount shall be based on the difference between a hospital's uncompensated care provision in its mark-up and the statewide uncompensated care average.

C. The Commission shall, at the same time, notify the General Accounting Division in writing of the:

(1) Hospitals [to be assessed a fee] due to remit for that month;

(2) Amount of the [assessment on each hospital} remittance for that month;

(3) - (5) Text Unchanged

D. Text Unchanged

.03 Payment of [Fee Assessment] Remittance Due

A. By [April 1, 1997] January 1, 2009, each hospital shall provide the Commission with sufficient banking information to facilitate the collection and disbursement of funds by the ACH or other wire transfer method. Each hospital shall initiate or authorize the ACH or other wire transfer method as directed by the Commission.

B. On or before the 5th business day of each month, each hospital [assessed a fee] identified as due to remit monies in accordance with these regulations shall make payment into the Hospital Uncompensated Care Fund in the manner prescribed by the Commission.

C. On or before the 5th business day of each month, the Comptroller shall transfer monies out of the Hospital Uncompensated Care Fund and distribute monies to hospitals in the manner prescribed by the Commission.

.04 Use of Funds

A. Funds generated through the [fee assessment] special rate adjustment and the remittance due may only be used to finance the delivery of hospital uncompensated care [and to fund the Uncompensated Care Reduction Program].

B. Interest earned from the monies collected shall be retained to the credit of the Hospital Uncompensated Care Fund.

C. Interest earned may be used to pay for the reasonable expenses associated with implementation of the alternative methodology approved by the Commission for financing the reasonable costs of hospital uncompensated care [and for reducing uncompensated care. The cost of procuring the Program Administrator is considered a reasonable expense for purposes of implementing the Uncompensated Care Reduction Program].

.05 Uncompensated Care Reduction Program. (Repealed)

.06 Failure or Delay in Paying [Fees] <u>Remittance</u>/Penalties.

(A) - (B) Text Unchanged

C. In addition to the penalties the Commission may impose on a hospital that fails to pay the [fee] <u>remittance</u> in a timely manner, the Commission may refer the hospital's delinquent account to the Department of Budget and Fiscal Planning's Central Collection Unit pursuant to the procedures in State Finance and Procurement Article, Title 3, Subtitle 3, Annotated Code of Maryland.

(D) - (F) Text Unchanged.

Attachment B

RECOMMENDATION 1: Approaches to Promote Practice Formation in Maryland

1. Establish an expanded loan program.
   a. The Health Services Cost Review Commission ("The Commission") should establish a program (LARP-State Only [LARP-SO]) to allow physicians in shortage areas as defined by the Office of Primary Care (OPC) at the Department of Health and Mental Hygiene (DHMH) to access the repayment program administered by DHMH and the Maryland Higher Education Commission (MHEC). The Task Force anticipates that OPC would address deficiencies in the federal definitions of provider shortage areas. Under the LARP-SO program, primary care physicians practicing in a state-defined shortage area could be eligible for loan repayment in exchange for a commitment to practice in the shortage area. The Commission should establish a program, provided that such a program:
      - is in the public interest;
      - is not in violation of the state's Medicare waiver under Section 1814(b) of the Social Security Act; and
      - does not result in significantly increasing costs to Medicare or placing the Medicare waiver in potential jeopardy.

   b. The Commission should consider various funding models when determining the most effective way to implement the loan repayment program, including:
      - A Nurse Support Program I approach, which provides additional funding to hospitals based on detailed proposals for use of the funds;
      - A Nurse Support II approach, which establishes a fund within MHEC and utilizes the expertise of MHEC to administer the loan repayment program;
      - The administrative creation of a fund within the Commission for this purpose as utilized for other Commission programs; and
      - Other appropriate funding models.

   c. In conjunction, the General Assembly should enact legislation:
      - To change the definition of eligible field of employment in 18-501 to include for-profit physician settings. (Note that under the current LARP program, this is not possible due to federal funding; however, this would not be an issue if funds come from the Commission)[16]; and
      - That allows other physician specialties to participate in loan forgiveness as long as the specialty has been identified as being in shortage in the area by DHMH.

RATIONALE Generating additional revenue from all payers for the state portion of LARP funding could be used to draw down additional federal funding and/or establish a state program with greater flexibility.

SOURCES OF FUNDING The amount to be included in hospital rates shall be based on an objective review of the need for the loan repayment program, but not to exceed 0.1 percent of hospital net patient revenue. This would be the primary source for the loan/development fund. If the funding plan meets the requirements of the Medicare waiver and CMS, the Commission currently has the authority to implement such a plan. A second source of funding comes from reallocating the portion of physician license fees currently

16 Under the J-1 visa waiver program designed to allow international medical graduates to practice in underserved areas, states and federal agencies requesting waivers for non-primary-care physicians are required to demonstrate a shortage of health care professionals able to provide services in that medical specialty for the patients who would be served by that physician, based on their own criteria, 8 U.S.C. § 1184(l)(1)(D)(iii). A similar provision does not exist under LARP.

assigned to loan assistance programs for nonphysician providers. In parallel, license fees for other allied health professionals may need to be increased modestly to sustain loan repayment programs in those professions once the physician license fees are reallocated.

TOTAL FUNDS AVAILABLE A surcharge of up to 0.1 percent on inpatient hospital revenues could generate up to $9.7 million (FY 2008) in inpatient revenue and up to $3.6 million from outpatient revenue.

Currently, 14 percent of the physician license fees are dedicated to loan repayment and split between two programs: (1) grants under the Health Manpower Shortage Incentive Grant Program, and (2) the Loan Assistance Repayment Program (LARP) for primary care physicians. For FY 2008, the grants awarded under the Health Manpower Shortage Incentive Grant Program totaled $499,098 and were split among 39 different postsecondary institutions in a number of health professional occupations. The LARP for primary care physicians in FY 2008 totaled $432,500, with an average of $25,441 provided to 17 physicians.

2. DHMH in collaboration with MHEC should establish a program that allows medical schools operating in Maryland to offer tuition assistance and admission preference to otherwise qualified in-state applicants who agree to stay and practice in shortage areas as defined by OPC for five years.

   SOURCE OF FUNDING A portion of funds generated under Option 1 should serve as the funding source for this initiative.

3. Medical practices should be eligible to participate in state technical assistance programs established by the Maryland Department of Business Development (DBED). Maryland provides business assistance funding to high-tech and bio-tech companies to enhance their service offerings. The state provides outside business consultants, entrepreneurial training, pro bono legal services, and additional networking opportunities with investors and assists in depth strategy planning. The MHCC and DBED should report to the General Assembly on the feasibility of expanding eligibility to state development programs to practices in medically underserved and health provider shortage areas.

4. Encourage insurers to provide incentive payments to practices in shortage areas for technology upgrades and practice development.

   RATIONALE Providing upfront IT improvement funding (similar to the CMS Electronic Health Record [EHR] demonstration currently under development in the state) eliminates a huge barrier to making these investments, will enhance quality improvement and patient safety initiatives, and may create leverage for additional federal funding under the CMS Medical Home Demonstration Project.

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

AS OF DECEMBER 1 , 2008

A: PENDING LEGAL ACTION : NONE
B: AWAITING FURTHER COMMISSION ACTION: NONE
C: CURRENT CASES:

Docket Number	Hospital Name	Date Docketed	Decision Required by:	Rate Order Must be Issued by:	Purpose	Analyst's Initials	File Status
1985A	University of Maryland Medical Center	6/4/08	N/A	N/A	ARM	DNP	OPEN
2009A	University of Maryland Medical Center	11/17/08	N/A	N/A	ARM	DNP	OPEN
2011R	Baltimore Washington Medical Center	12/24/08	1/23/09	5/23/09	ICU/CCU	CO	OPEN
2012A	Johns Hopkins Health System	12/24/08	N/A	N/A	ARM	DNP	OPEN

PROCEEDINGS REQUIRING COMMISSION ACTION - NOT ON OPEN DOCKET

None

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION	*	**COMMISSION**	
UNIVERSITY OF MARYLAND	*	**DOCKET:**	**2008**
MEDICAL CENTER	*	**FOLIO:**	**1795**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**1985A**

Staff Recommendation

January 14, 2009

V. STAFF EVALUATION

The staff reviewed the experience under this arrangement for the FY 2008 and found it to be unfavorable. When questioned about the unfavorable experience, Hospital representatives explained that an outlier BMT case during the period generated hospital charges that were approximately 5 times greater than the average for that type of case. The patient in this case developed a rare complication, diffuse aveolar hemorrhage, which required intensive immune support and a prolonged stay in intensive care. However, staff found that the experience in the first quarter of FY 2009 was favorable, although it includes only one BMT case.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospital's application for an alternative method of rate determination for liver and blood and bone marrow transplant services, retro-active to February 1, 2008 through June 30, 2009, but that continued participation in this arrangement beyond June 30, 2009 be based on favorable experience in FY 2009. The Hospital will be required to file a renewal application in order to be considered for continued participation.

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

IN RE: THE PARTIAL RATE	*	BEFORE THE HEALTH SERVICES
APPLICATION OF	*	COST REVIEW COMMISSION
BALTIMORE WASHINGTON	*	DOCKET: 2008
MEDICAL CENTER	*	FOLIO: 1821
BALTIMORE, MARYLAND	*	PROCEEDING: 2011R

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Staff Recommendation

January 14, 2009

Introduction

On December 24, 2008, Baltimore Washington Medical Center (the "Hospital") submitted a partial rate application to the Commission requesting its July 1, 2008 Medical Intensive Care Unit (MIS) and Coronary Care Unit (CCU) approved rates be combined effective January 1, 2009. This rate request is revenue neutral and will not result in any additional revenue for the Hospital, but only involves the combining of two revenue centers. The Hospital wishes to combine these two centers as they will be physically combined into one unit in the new tower built by the hospital. The Hospital also wishes to combine the two centers because the patients have similar staffing needs, and placement into an ICU or CCU unit is often based on bed availability or staffing rather than on a diagnosis. The Hospital's currently approved rates and the new proposed rate are as follows:

	Current Rate	Budgeted Volume	Approved Revenue
Medical/Surgical ICU	$2,102.35	3,622	$7,614,720
Coronary Care	2,016.52	3,684	7,428,853
Combined Rate	2,059.07	7,306	15,043,573

Recommendation

After reviewing the Hospital's application, the staff recommends that the hospital be allowed to collapse its Coronary Care rate into its Medical Intensive Care rate effective January 1, 2009.

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**
DETERMINATION	*	**COMMISSION**
JOHNS HOPKINS HEALTH	*	**DOCKET: 2008**
SYSTEM	*	**FOLIO: 1822**
BALTIMORE, MARYLAND	*	**PROCEEDING: 2012A**

Staff Recommendation

January 14, 2009

I. INTRODUCTION

On December 24, 2008, Johns Hopkins Health System ("System") filed a renewal application on behalf of its member hospitals, Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, and Howard County General Hospital (the "Hospitals") requesting approval from the HSCRC to participate in a global rate arrangement for cardiovascular services with Olympus Managed Health Care, Inc. The Hospitals request that the Commission approve the arrangement for a period of one year beginning January 1, 2009.

II. OVERVIEW OF APPLICATION

The contract will be held and administered by Johns Hopkins HealthCare, LLC ("JHHC"), which is a subsidiary of the System. JHHC will manage all financial transactions related to the global price contract including payments to the System hospitals and bear all risk relating to regulated services associated with the contract.

III. FEE DEVELOPMENT

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

IV. IDENTIFICATION AND ASSESSMENT OF RISK

The Hospitals will submit bills to JHHC for all contracted and covered services. JHHC is responsible for billing the payer, collecting payments, disbursing payments to the Hospitals at their full HSCRC approved rates, and reimbursing the physicians. The System contends that the arrangement among JHHC, the Hospitals, and the physicians holds the Hospitals harmless from any shortfalls in payment from the global price contract. JHHC maintains it has been active in similar

types of fixed fee contracts for several years, and that JHHC is adequately capitalized to bear risk of potential losses.

V. STAFF EVALUATION

After review of the data utilized to calculate the case rates, staff is satisfied that the hospital component of the global price is sufficient to achieve favorable performance under this arrangement.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for cardiovascular services for the period from January 1, 2009 through December 31, 2009. The Hospitals must file a renewal application annually for continued participation in this arrangement.

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

DRAFT RECOMMENDATION OF REVISIONS TO THE REASONABLENESS OF CHARGES (ROC) METHODOLOGY

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January 14, 2008

This document is a draft staff recommendation to the Commission at the January14, 2008 public meeting

INTRODUCTION

Over the past year, staff, working with payer and industry representatives, has engaged in a process to review and revise the Commission's Reasonableness of Charges (ROC) methodology. [1] This draft recommendation proposes a series of changes to the ROC process that are the result of those discussions. The recommended changes to the ROC methodology will be used to calculate a ROC in early February 2009.

BACKGROUND

The Commission's ROC process is intended to allow hospitals to be compared on an equal footing to determine if a hospital's charges are reasonable relative to other peer hospitals in Maryland. A hospital with charges that are too high relative to its peers may be subject to "spend-down" provisions, where its rates are lowered to bring the hospital's charges in line with statewide averages. Conversely, a hospital where charges are low relative its peers may apply to the Commission for a "full rate review" and see rates increased consistent with Commission policies.

The ROC and the accompanying Interhospital Cost Comparison (ICC) are central elements of the Commission's mission to promote cost effective and efficient hospital services in Maryland. In addition to triggering "spenddowns" or permitting hospitals to request "full rate reviews," the ROC also provides feedback to hospitals on their performance relative to their peers. A stable ROC/ICC process is essential if it is to have its intended effect: aligning hospital rates with the resources needed to serve patients efficiently. It is also necessary to provide hospitals with feedback on their positions relative to their peers so that the hospital may take appropriate actions improve their positions.

The ROC analysis, or something similar[2], has been a consistent feature of the Commission's rate setting process. The methods used in the analysis, however, are not static. Changes in Commission policies and practices require the ROC analysis to be revised if it is to compare hospitals fairly.

The ROC process in use in 2005 began with each hospital's approved Charge Per Case (CPC) and made a series of adjustments to arrive at an adjusted CPC. The adjusted CPC was then used to compare hospitals within five defined peer groups. The adjustments were:

- *Mark-up,* the additional charges that each hospital is allowed to bill in order to account for its unique circumstances, including payer mix and the hospital's uncompensated care experience;

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[1] The Commission did conduct a limited ROC using the previous (2005 and earlier) methodology in the spring of 2008. As a result three hospitals with adjusted charges well below their peers filed full rate reviews and, consequently, received an upward adjustment in rates. A number of other hospitals were identified as being considerably above the mean of their peers and could have be required to "spenddown. " The Commission chose not to take spenddown action in light of the anticipated comprehensive overhaul of the ROC.

[2] Earlier versions of the ROC process were referred to as the "screens", as each hospitals charges were screened according to a number of parameters.

- *Labor Market Adjustment,* an adjustment to account for varying labor costs that Maryland hospitals are subject to;
- *Hospital Case Mix*, an adjustment to account for the varying resource needs of treating the hospitals' patient populations;
- *Direct Strips*, specific dollar amounts removed from the calculation of the hospital adjusted CPC to adjust for a portion of the costs of resident salaries (DME) and some of the incremental costs of trauma centers;
- *Indirect Medical Education,* an adjustment to account for the differing costs associated with having a teaching mission; and,
- *Capital,* an adjustment to reflect the capital cycle when comparing hospital costs.

Transition to APR-DRGs and Impact on ROC

While all of the adjustments are important to allow hospitals to be compared on an equal footing, they are not all of equal magnitude. The most significant adjustment (in terms of difference between the lowest and largest adjustment) is for hospital case mix. This is to be expected, as the relative patient acuity across hospitals should be the most significant factor in determining the resources needed to treat those patients. Since case mix is such an important factor in the ROC analysis, changes in the methods to measure case mix inevitably lead to changes in the ROC process. Improvements to case mix measurement affects other ROC adjustments that previously captured some case mix variation, requiring that those adjustments be re-examined.

The Commission's conversion from Diagnostic Related Groups (DRGs) to All Patient Refined-Diagnostic Related Groups (APR-DRGs) in 2005 represented a substantial improvement to the Commission's ability to measure hospital case mix accurately. APR-DRGs expand upon the older DRGs by breaking each DRG into 4 severity levels, each of which is then assigned a weight to account for the relative resource use of patients in each APR-DRG cell. As a practical matter, the Commission went from breaking patient care down into roughly 300 resource similar categories to 1200 clinically relevant and resource-similar categories.

The introduction of the APR-DRGs also provided hospitals with a strong incentive to improve the coding of discharge data submitted to the Commission.[3] Since the APR-DRGs more fully account for the resource use of patients based on severity, complete medical record documentation and accurate coding are vital to assuring that a hospital's rates are commensurate with the needs of its patient population. It was common to see hospitals substantially increase depth of coding in the course of a single year. That change however, did not occur in the same pace or at the same time for all hospitals. Finally, the change to APR-DRGs also led to large increases in measured case mix that were not associated with changes in underlying resource use, leading to the imposition of limits in case mix growth (governors).[4]

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[3] All Maryland hospitals report discharge data on all patients to the HSCRC on a quarterly basis.

[4] The Maryland experience was analyzed by CMS in advance of the introduction of CMS-DRGs and has led to federal provisions to limit case mix growth during the transition to CMS-DRGs.

These changes in the completeness of medical record coding in the years immediately after the introduction of APR-DRGs caused the Commission to place a moratorium on the ROC process (and its attendant spenddowns and full rate reviews). The Commission decided that conducting the ROC analysis was inappropriate, as the measurement of the relative case mix across hospitals (a central adjustment in the ROC process) was not reliable until coding improvement reached a steady state.

Analysis of more recent submissions of hospital discharge data show that the transition in coding practices initiated by the use of APR-DRGs is now complete. In 2005 the percentage of discharges that reported 15 diagnoses was 6 percent, as of the first 6 months of FY2008 discharges that reported 15 or more diagnoses exceeded 20 percent. Furthermore, the depth of coding across hospitals is consistent.

Introduction of Charge Per Visit Methodology

A second major change to the rate setting system since the last ROC process in 2005 is the implementation of the Cost Per Visit (CPV) methodology for outpatient services. As with the Charge Per Case target system that has been in use since 2002, the CPV reflects the hospital's expected charge per outpatient case on a risk adjusted basis, although in this case, the risk adjustment relies on Enhanced Ambulatory Patient Groups (EAPGs). The CPV methodology for outpatient services was approved by the Commission on June 4, 2008.

The CPV methodology uses the FY2008 outpatient data as the baseline to establish CPVs for all Maryland hospitals. Prior to the introduction of the CPV, the Commission set rates for individual units of outpatient services (lab, emergency room, etc.) but did not set an overall, risk adjusted target for the visit that those outpatient services comprised. Without such a target, a ROC process for outpatient services was not possible. Instead, once a hospital's position relative to its peers was determined by using the inpatient based ROC, an assessment of the hospital outpatient charges relative to the statewide median was done prior to imposing spenddowns or considering a hospital for a full rate review.

The introduction of the CPV has provided the Commission with two comprehensive measures: one of inpatient cases; and, one of outpatient visits. It has always been the Commission's intent that outpatient charges should be assessed for their reasonableness as inpatient charges are; with the introduction of the CPV such an assessment is possible.

REVISIONS TO THE ROC METHODOLOGY

The completion of the APR-DRG transition and the implementation of the CPV methodology demanded a thorough review and revision of the ROC process. Toward that end Commission staff, along with payer and industry representatives have engaged in a year-long process to revise and update the ROC methodology. In discussing the recommended changes to the ROC, the workgroup addressed a number of disparate and complex issues. It is useful to group the issues into several broad categories:

- *Baseline Issues* These issues relate to the baseline hospital charges upon which later adjustments are made. The baseline issues addressed were the Commission's trim

point methodology and the blending of the inpatient charge per case and outpatient charge per visit;

- *ROC Adjustments* These are the adjustments are made to a hospital's baseline charge to allow a "like-to-like" comparison of peer hospitals. These can be further broken down into:

  Major Adjustments Adjustments that have a significant impact on a hospitals baseline charges. Major adjustments are: Case Mix, Indirect Medical Education, and Disproportionate Share; and,

  Minor Adjustments While important to assuring a fair comparison across hospitals these adjustments are relatively small. Minor adjustments are; Direct Strips (Direct Medical Education, Trauma Hospitals, Nursing Education), Labor Market, and Capital Adjustments.
- *Comparing Hospitals* This pertains to the peer groups that hospitals are broken into once charges have been adjusted it is a hospitals performance relative to its peer group that determines how the ROC effects that hospital; and,
- *Implementation Issues* These are issues that pertain to how the ROC is applied in the setting of hospital rates. Implementation issues include: the setting of spenddown thresholds and/or scaling; whether to conduct of an annual or semi-annual ROC.

Baseline Issues

The ROC process started with each hospital's allowed CPC. A series of adjustments were then made to the CPC to arrive at an adjusted CPC, which is used as the "like-to-like" comparison. The starting point at which later adjustments are made influences the outcome of the ROC.

Trim Points. Trim points are dollar thresholds[5] at which charges for a specific case are not included in the calculation of a hospital's CPC. The current HSCRC policy sets statistically defined individual trim points for each hospital and for each APR-DRG cell. An alternative trim point policy (which was considered in 2005 when the current trim point methodology was established) would have established a statewide set of trim points for each APR-DRG cell. Staff believes that the current trim point methodology is not the most desirable; it is overly complex - establishing over 100,000 trim point compared with roughly 2,400 for the alternative methodology- and its complexity to does not provide any additional policy benefit.

In addition to its complexity, the trim point methodology also influences the other adjustments that are used in the ROC. At the July 8, 2008 meeting of the ICC/ROC workgroup, the representatives of the teaching hospitals presented analyses that showed that the current trim policy of hospital specific trims had the effect of increasing the ROC adjustment for IME, compared with the alternative of individual APR-DRG trims. This was because the current trims tend to increase the charges included for the calculation of CPCs for teaching hospitals (in particular the Academic Medical Centers). The representatives of the G-9 (non-teaching hospitals) agreed that this would be the effect of such a change to the trim policy. The trim point methodology is therefore, intertwined

[5] Charges above the trim points are essentially 'pass throughs' that payer reimburse as charged; they are not subject to the constraints of the CPC system.

with the IME methodology and influences the results that are obtained from such analysis.

The current methodology however, is in place, and the hardest technical and administrative tasks are complete. Furthermore, changing the trim point policy will also create timing problems. A change in the trim policy will not take effect until the FY10 rate year, meaning that CPCs with the new trims will not be available until FY11.

STAFF RECOMMENDATION: CONTINUE TO USE THE CURRENT TRIM POINTS The current trim point methodology should remain in place. Staff does not feel that the current trim policy is optimal. The administrative burdens of the current trim methodology however, have already been absorbed by the Commission and the hospitals and a change to the trim policy will add administrative costs – without sufficient offsetting benefit. Staff may wish to revisit the trim policy at a future date, after the recommended revisions to the ROC methodology are implemented. At such a time revision of the trim policy can be considered in isolation, and not as a factor that has confounding effects on other ROC adjustments.

Blending Charge Per Case and Charge Per Visit Calculations. The Commission has an established policy for its CPV. It is also the stated intent of the Commission to analyze hospitals for their efficiency on the CPV (i.e. a CPV ROC). Measuring hospital efficiency separately on an inpatient (CPC) and outpatient (CPV) basis presents several problems:

- *Combining a positive position on inpatient with a negative position on outpatient.* While such a separate comparison is possible, and in fact has been done by the Commission over time, it is less appropriate when combining case targets such as the CPC and the CPV. The Commission and the hospitals will be engaged in two parallel activities combining them at the end.
- *Peer group comparisons.* Peer groups were based on the appropriateness of grouping similar hospitals to allow reasonable comparison. One of the key elements of a peer groups is hospital size. For outpatient departments, size (i.e., volume) of outpatient departments varies widely across hospitals and does not follow current (or proposed) peer groups. Thus a stand-alone CPV ROC would need to consider alternative peer groups, further disconnecting the analyses.
- *IME adjustment.* An IME adjustment for outpatient would also be necessary; however, determining the appropriate variables to use for the measurement of IME would be quite complex. For example, the use of a resident to bed ratio to measure the intensity of the medical teaching component for outpatient services is questionable.

STAFF RECOMMENDATION: BLEND THE CPC AND CPV INTO A SINGLE COMPREHENSIVE CHARGE TARGET (CCT) Staff believe that the best way to address these problems is not to conduct the ROC in a bifurcated manner. The purpose of the ROC is to measure the overall reasonableness of hospital charges. The introduction of the CPV, along with the current Commission practice of aligning inpatient and outpatient charges each year makes a comprehensive approach possible.

Staff recommends that each hospital's CPC and CPV be blended into a single Comprehensive Charge Target (CCT). An analogous blending of case mix (discussed below) will also be done. The CCT will be the starting point for the ROC analyses. The ROC adjustments will then be applied to the CCT to arrive at a final, adjusted CCT. The method for blending CPC and CPV is presented in Attachment 1.

The blended CCT addresses the key challenges highlighted above:

- *Conflicting inpatient and outpatient ROC results.* If a hospital is differentially efficient on an inpatient versus an outpatient basis that will be reflected in the blended CCT.
- *Peer groups.* Since inpatient revenues included in the CPC dwarf outpatient revenues included in the CPV the blended CCT does not substantially change the utility of peer groups as they are currently defined for inpatient.
- *IME adjustment.* The IME adjustment will be made on the overall CCT so there will be no need to develop separate CPC and CPV adjustments.

ROC Adjustments

Using the CCT as the starting point, the ROC analysis makes a series to adjustments. The adjustments yield a final, adjusted CCT that is used to compare hospitals to their peers. For presentation purposes, these adjustments can be classified as major adjustments – those that can substantially change a hospital's CCT, or minor adjustments – those that have a modest effect on the CCT.

Major Adjustments

Case Mix. The Commission accounts for case mix differences across hospitals on the inpatient side using the APR-DRG grouper, this system has been in use since 2005. As was discussed above, the changes in medical record documentation and coding that were induced by the introduction of APR-DRGs are complete. Outpatient case mix is determined using the EAPG grouper according to the policy approved by the Commission in June 2008. Unlike the inpatient grouper, outpatient case mix as determined by the EAPG grouper is not materially changed by changes in hospital medical record coding practices.[6] While the EAPG grouper has been in use for less time, staff believes that it accurately measures outpatient case mix across hospitals.

STAFF RECOMMENDATION: COMBINE INPATIENT AND OUTPATIENT CASE MIX INDEXES INTO A SINGLE ADJUSTMENT.

This recommendation logically follows from the blending of inpatient CPC and outpatient CPV. During the development of the outpatient Charge per Visit (CPV) system, case weights for significant procedure visits were calculated using two different methods: 1) case weights were assigned based on the principal APG (the highest weight) in the record; or 2) case weights were assigned based on 100 percent of the principal APG weight and partial weight for subsequent APGs in the record. Given the minimal increase in the explanatory power by use of multiple APGs (method 2), and the ease of monitoring when using a single APG for the case mix adjustment (method 1), HSCRC

[6] Unlike APR-DRGs, EAPGs make much greater use of procedure codes in assigning patient visits. The presence of additional diagnostic detail has very little effect on EAPG assignments.

staff recommended that the principal APG be used for the assignment of case weights in the CPV system.

During the ICC/ROC workgroup meetings, industry representatives expressed satisfaction with the case mix methodology used in the outpatient CPV system because each hospital's rate year performance is compared to its own base year performance. However, workgroup members stated the current CPV case mix methodology may be unfair when comparing the reasonableness of outpatient charges between hospitals considering that some hospitals may provide more multiple significant procedures within a visit compared to other hospitals. Commission staff agreed that this was a valid concern are proposing a revised outpatient case mix methodology to be used for the ROC. This methodology will provide partial weight for subsequent significant procedure APGs as follows:

The case weight will be based on 100 percent of the singleton weight for the highest weight APG, 65 percent of the singleton weight for the second highest weight APG, and 65 percent of the singleton weight for the third highest weight APG[7]. The resulting case mix index would be used in the February, 2009 ROC.

Indirect Medical Education (IME) The Commission has long recognized that a hospital's teaching mission adds some costs that need to be accounted for, if a fair comparison across hospitals is to be conducted. Some of these costs, such as the salaries of residents, can be readily quantified, and these direct costs are discussed below. In addition, the Commission recognizes that other costs associated with a teaching mission are not so easily measured. These indirect costs[8] need to be accounted for in the ROC. In the previous ROC the Commission used a regression analysis to arrive at an estimate of the impact of IME on teaching hospitals.

As in the past, the IME adjustment for the ROC was a source of considerable discussion. Part of this is due to the use of regression analysis as a tool to measure the IME effect. It is the nature of a regression that when there are a limited number of observations (such as 47 Maryland hospitals) only a limited number of variables can be tested, and those variables may end up capturing other, unrelated, effects.

Several participants in the workgroup argued that the methodology used to estimate IME for the previous ROC would result in an adjustment that would be too large, i.e., it would attribute more cost to a hospital's teaching mission than was appropriate. One source of this problem is the fact that many teaching hospitals are in urban settings and tend to serve more disadvantaged patients. A portion of the IME estimate was therefore, likely to be a measurement of services to this disadvantaged population.

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[7] It is also staff's plan to revise the CPV methodology for the upcoming rate year to reflect this more refined approach to outpatient case mix. Assuming this change, future ROC analyses will not require that this additional case mix modification be made.

[8] The Commission is not alone in its recognition of the added costs associated with a hospital's teaching mission. The Medicare Prospective PaymentSsystem (PPS) has included an adjustment for teaching since its inception in 1982.

Disproportionate Share (DSH) adjustment. The Commission has a history of making what it calls a disproportionate share adjustment to account for the additional resource needs associated with treating large shares poor, high need patients. [9]The purpose of this adjustment is to account for additional costs (additional discharge planning, social work staff, etc) that hospitals treating a poorer population may incur. At different times in the past, the Commission has used a regression analysis a variable for the share of hospital charges to Medicaid patients to measure this burden. In ROC analyses prior to 2005 however, this adjustment had ceased to have any statistical validity, or worse, produced results that were illogical. For these reasons, the DSH adjustment was dropped from the calculation of the ROC.[10]

During the course of this year's ROC review analysis by staff, the teaching hospital group and the G-9 (non-teaching hospitals) have shown that regression analyses that adjust for teaching status and include a measure of the level of poor served by the hospital are statistically significant and logically consistent.[11] Staff strongly believes that a DSH adjustment should be reintroduced to the ROC with the IME adjustment. This adjustment is especially important, as staff hold that without a DSH adjustment the allowance for IME calculated by a regression will overstate the IME effect and distort the ROC comparisons.

STAFF RECOMMENDATION: INCLUDE REGRESSION BASED ADJUSTMENTS FOR IME AND DSH IN THE ROC ANALYSES The ROC should include adjustments for IME and DSH. These adjustments should be calculated via a regression analysis that introduces teaching intensity and high need share as separate independent variables. The measures used for teaching intensity and high need share have a substantial impact on the ROC. Staff recommends that these variables be calculated as follows:

- *Teaching intensity.* Teaching intensity will be measured by the number of trainees (residents and fellows) per risk adjusted discharge. For the ROC, a resident or fellow is defined as someone who is actively enrolled in an Accreditation Council for Graduate Medical Education (ACGME) accredited training program (the number not to exceed the limit set by ACGME), and who is actively engaged in patient care at the hospital (either inpatient or in a hospital based clinic) on the first Tuesday after Labor Day. This measure of teaching intensity differs significantly from the one used in earlier ROC analyses. Those analyses used a resident per bed ratio, where residents were limited to those who had not yet finished a residency (e.g. physicians in sub-specialty programs were not counted). Staff believes that this earlier approach was

[9] Disproportionate Share Hospitals (DSH) is a term used by the federal Medicaid program to allow for specific payment arrangements by state Medicaid programs. The Commission's rate setting process largely eliminates such payment arrangements in Maryland, and the Commission's use of the term DSH should not be confused with the federal Medicaid policy.

[10] No DSH adjustment was made in the Spring 2008 ROC.

[11] There are several possible reasons why estimates of a DSH effect are statistically valid using current data, including: the blended CCT is a better basis for comparing hospital charges than inpatient alone; or, the variable to measure teaching intensity is different from previous ROC analyses.

incorrect as it artificially limited the number of individuals involved in medical training (especially at the Academic Medical Centers) and had the effect of overweighting the IME effect of each resident.

- *High need share.* The high need share will be calculated as the percentage of a hospitals included charges accounted for by the following groups: inpatient and outpatient charges for individuals where Medicaid is the primary payer; inpatient and outpatient charges for individuals where self pay or charity care is the primary payer; and, inpatient charges where Medicare is the primary payer and Medicaid is the secondary payer.[12]

Minor Adjustments

Adjustment for Direct Medical Expenses: The current methodology uses a calculation to determine the cost of residents and then removes 75 percent of these costs from hospital revenue when calculating the ROC. There has been discussion as to whether the amount of revenue adjusted for should be increased to 100 percent and the calculation revisited. This issue directly bears on the IME discussion. Direct medical costs that are stripped will not be accounted for in an IME methodology and, conversely, direct medical costs that are not stripped will be picked up by an IME methodology.

STAFF RECOMMENDATION: THE DIRECT COST PER RESIDENT SHOULD CALCULATED AND 100 PERCENT THOSE COSTS REMOVED FROM A HOSPITAL'S CHARGES WHEN CALCULATING THE ROC.

Labor Market Adjustment. Each year the Commission gathers data from hospitals on the cost of various personnel categories in the hospital and the zip codes in which staff live. This data is then analyzed to create a labor market index that accounts for differing personnel costs the hospital faces.

STAFF RECOMMENDATION. THERE SHOULD BE NO CHANGE TO THE CALCULATION OR USE OF THE LABOR MARKET INDEX.

Adjustment for Capital In the 2005 ROC, a capital adjustment was the final step in the ROC, performed after hospital charges had been adjusted for Indirect Medical Expenses. The adjustment takes hospital capital costs (interest, depreciation, and certain leases) as reported on the hospital's ACS schedule of the annual report as a percentage of reported total costs. The hospital ROC charges are then adjusted by taking the sum of one half the hospitals capital costs plus one half of the hospital's peer group average capital costs. The effect of this adjustment is to improve a hospital's relative position on the ROC at the beginning of its capital cycle when capital costs are high, and, conversely, a hospital with low capital costs would see its ROC position deteriorate.

[12] Including Medicaid as secondary payer this measure captures poor elderly individuals who have Medicare as the primary payer.

During the ROC review staff raised questions as to whether any capital adjustment was needed to compare hospitals under the ROC. Staff argued that hospitals should manage their capital cycle as they manage other costs. Under this reasoning, capital costs are but one, relatively small element of a hospital's costs within the control of the hospital.

Others in the workgroup held that a capital adjustment was necessary to maintain consistency between the ROC methodology, which compares hospital relative efficiency, and the ICC, which is used to determine rate adjustments for specific hospitals. Since the Commission has a process to adjust rates specifically for changes in capital costs (Partial Rate Reviews for Capital) it is possible that were it not for the capital adjustment, a hospital that was given an upward rate adjustment under the ICC process could subsequently see its rates reduced due to poor performance on the ROC.

STAFF RECOMMENDATION: CREATE AND APPLY A STATEWIDE CAPITAL ADJUSTMENT IN THE ROC Staff recommends that the ROC continue to have a capital adjustment but that the method and order of the adjustment be modified. The capital adjustment should be an index that is created by the sum of one half the hospital's capital costs plus one half of the statewide average capital cost. In the ROC process, all adjustments are either hospital specific or based on statewide analysis. The peer group specific capital adjustment is inconsistent with the rest of the methodology. Furthermore, the capital adjustment should be made prior to doing the regression analysis to estimate the IME and DSH adjustments. The ROC methodology is a series of adjustments that, in the end, lead to an adjusted charge per case number for each hospital that is used to compare the relative efficiency of hospitals. In such an analysis, the order of operation influences the results. The mechanics of regression are such that any effect (such as capital) that is not measured or accounted for will, to some extent, be captured by what is measured, i.e., if the capital adjustment is done after the regression adjustment for IME and DSH, the capital effect is double counted.

Comparing Hospitals.

Peer Groups The current ROC analysis compares hospitals against one and other in one of five distinct 'peer groups.' These peer groups match hospitals according to several factors (size, location, etc) and are intended to assure the ROC goal of a like-to-like comparison. The peer groups have long been used by the Commission for it ROC and ICC processes. The original need for the peer groups was that the tools that the Commission had to compare hospital were not sufficient to capture the differing circumstances of all hospitals. The average charge of different peer groups could be quite different.

The use of the APR-DRG system substantially improves the Commission's ability to measure the relative differences in hospital case mix.[13] Likewise, the DSH adjustment proposed earlier accounts for other difference in patient characteristics that can drive hospital costs. One result of these and other ROC adjustments is the difference in the average adjusted charge among peer groups is relatively small. During the workgroup

[13] Unmeasured patient severity was consistently cited as one of the factors that required hospitals to be grouped by peer group.

discussions two points were made regarding peer groups. First, if the variation in peer group average is small does analysis by peer groups serve any purpose? A second point made the G-9 (a group of non-teaching hospitals) was that these small variations in peer group means were, in fact, unfair as they held some hospitals to a lower adjusted charge standard than other hospitals in a different peer groups. Some in the workgroup argued that peer groups remain necessary as they continue to account for some unmeasureable variation among hospitals that is not accounted for in the ROC analysis.

STAFF RECOMMENDATION: THE UPCOMING ROC ANALYSIS SHOULD CONTINUE TO BE DONE ON A PEER GROUP BASIS, BUT THAT THE ISSUE OF PEER GROUPS SHOULD BE REVIEW IN THE COMING YEAR AND THE OPTION OF NO LONGER USING PEER GROUPS BE SERIOUSLY CONSIDERED. Staff is very skeptical about the continued utility of peer groups for the ROC process. Staff feels that with the improvements in case mix measurement and the accounting for DSH the major reasons for the creation of peer groups has been addressed. Staff will engage in discussion and analysis with the industry and payers to assess whether the ROC should be conducted on statewide basis, or whether an alternative from the current grouping is more appropriate.

ICC and Implementation Issues

These issues relate to how the ROC is applied and the actions the Commission may take based upon the results of the ROC. These issues are not methodological, but rather pertain to the application of the ROC and its results.

Scaling and Spenddowns One likely effect of the ROC moratorium that has been in effect since 2005 is that the differences among hospitals as determined by the ROC analysis are likely to have increased. This is likely due to two factors: first, the APR-DRG system may have identified case mix differences among hospitals that the earlier less precise DRG system did not; and, second, the moratorium means that for four years the Commission took no actions (aside from the limited ROC in January 2008) to adjust the rates of hospitals that were falling less in line with their peers. An early concern of the workgroup was that a revised methodology could lead to spenddown orders of a magnitude that would be extremely difficult for hospitals to comply with. As an alternative to spenddowns the workgroup discussed the use of scaling, whereby a hospital's yearly rate update is adjusted up or down depending on the outcome of the ROC.

STAFF RECOMMENDATION: THE COMMISSION SHOULD IMPOSE NO SPENDDOWNS BASED ON THE 2009 ROC, BUT IT SHOULD INSTEAD SCALE THE FY 2010 UPDATE FACTOR. Staff recommends that there be no spenddowns based upon for the upcoming ROC. This recommendation only applies to 2009 ROC analysis. Based on the results of that ROC, staff proposes that the Rate Year 2010 update include a scaling methodology based on the hospital's position on the ROC. The use of spenddowns and scaling in later years is still to be determined.

The scaling methodology recommended by staff represents a modification of a proposal made by MHA during the review process. The scaling methodology should apply the following parameters:

- Upper and lower bounds of scaling. The scaling should begin at one half of a standard deviation above or below the peer group mean. Any hospital whose ROC position is greater than one standard deviation above or below the peer group mean should be subject to the maximum scaling reward or penalty.
- Relationship of scaling to the rate update factor. The highest reward or penalty should be 33percent of the base update factor.
- Scaling should be continuous. MHA proposed two level of either positive or negative scaling between the upper and lower bounds. Staff feels that the differentials between those "notches" is too great - 0.9% in the MHA example. Such a large differential effect among hospitals that have almost identical results has two problems: first it is inequitable; and, second, it will inevitably lead to contentious disputes between hospitals and Commission staff. Staff recommends that continuous scaling be applied between the high and low boundaries.

Annual vs. semi-annual ROC/ICC Historically, the Commission has conducted the ROC twice a year. This twice a year schedule allowed for new information to be accounted for and appropriate actions to be taken. During the review process hospitals have suggested that a single annual ROC may be an appropriate schedule.

STAFF RECOMMENDATION: THERE SHOULD ONLY BE A SINGLE ROC ANALYSIS CONDUCTED IN 2009 Since the Staff is recommending that no spenddowns be imposed based on this ROC, and that a scaling methodology be applied to the update factor, there is no need to conduct a semi-annual ROC in the upcoming year. Staff further recommends that there continue to be discussions with payer and the industry in the coming year to consider the most appropriate schedule for the ROC analysis and action based on that analysis.

Intergrating the ROC and the ICC The ROC analysis determines hospital position relative to one another. The ICC is the process that the Commission uses to determine the exact magnitude of any rate adjustment that may result from the ROC. It is therefore, important that these processes are integrated to give consistent results. Some of the revisions to the ROC methodology require adjustments to the current ICC methods to maintain consistency.

STAFF RECOMMENDATION: CONTINUE TO WORK WITH THE INDUSTRY AND PAYERS TO ADDRESS ISSUES RELATED TO THE INTEGRATION OF THE ROC AND THE ICC.

SUMMARY OF RECOMMENDATIONS

Establishing hospital baseline charges

- Continue to use the current trim points.

- Blend the CPC and CPV into a single comprehensive charge target (CCT).

ROC adjustments

Major adjustments

- Combine inpatient and outpatient case mix indexes into a single adjustment.

- Include regression based adjustments for IME and DSH in the ROC analyses.

Minor adjustments

- The direct cost per resident should calculated and 100 percent those costs removed from a hospital's charges when calculating the ROC.

- There should be no change to the calculation or use of the labor market index.

- Create and apply a statewide capital adjustment in the ROC.

Comparing hospitals

- The upcoming ROC analysis should continue to be done on a peer group basis, but peer groups should be reviewed in the coming year and the option of no longer using peer groups should be seriously considered.

Implementation issues

- The commission should impose no spenddowns based on the upcoming ROC, but it should instead scale the FY 2010 update factor.

- There should only be a singly ROC analysis conducted in 2009.

- Work with the industry and payers to address issues related to the integration of the ROC and the ICC.

Attachment 1

There is broad agreement that in order to better compare Maryland hospitals across all spectrum of care and services regulated by the HSCRC, the Reasonableness of Charge Analysis (ROC) be expanded beyond its present scope (Charge per Case comparison) to a comprehensive comparison that includes outpatient services - Ambulatory Surgery, ER, and Clinic. To do this, a method of combining the Charge per Case (CPC) and Charge per Visit (CPV) needs to be crafted.

The aim of a combined CPC and CPV methodology is two-fold:

1. The standardization of weights under the APR DRG and APG systems;
2. The redefinition of outpatient visits in relation to inpatient cases.

Moreover, the combined methodology should be simple and intuitive without disrupting the existing underlying assumptions of the ROC. The results are the "Equivalent Inpatient Case" (EIPC), the "Comprehensive Charge Target" (CCT), and the accompanying "Overall Casemix Index" (CMI), which represent for each hospital the number of patients, the average charge, and intensity of the patients, all of which may appropriately be compared among peer group hospitals.

The attached table details staff's calculation and standardization of the combined or blended inpatient and outpatient ROC input variables. Please note that the numbers contained in the table are for discussion purposes only, as they do not represent numbers to be used in the upcoming ROC.

When reviewing this table, there are two key underlying assumptions to the calculations to keep in mind:

1. The outpatient weight of 1.0 equals the average CPV (which equals Outpatient Visit Standardizing Factor (OVSF) multiplied by average CPC, 0.07382 x $10,007). By using a statewide OVSF as a conversion factor, the variation across hospitals' outpatient services is maintained. Moreover, the use of the OVSF mitigates passing through to the CCT hospitals differential efficiencies and/or inefficiencies on inpatient versus outpatient bases, since charges for like goods and services are deemed consistent across inpatient and outpatient settings.
2. The weights for each class of outpatient revenue must be consistent with each other if they are calculated separately.

The columns in the first row of the table list all the names of the variables used in the calculations starting from "HOSPID" in column 1, and ending with "Comprehensive Charge Target" in column 20. The columns in the second row of the table are numbered 1 thru 20. When necessary, the column number is equated to a formula that shows how that column is

derived. To illustrate how the calculations are done, let us use Anne Arundel Medical Center, which is the first hospital in the table, as an example.

To calculate the hospital's EIPC, CCT, and CMI, first calculate the hospital's inpatient revenue and inpatient casemix weight under the Charge per Case System. The inpatient revenue, Column 5, is calculated by multiplying the hospital's inpatient cases (Column 3) by the CPC (Column 4). The inpatient casemix weight, Column 7, is calculated by multiplying the hospital's inpatient cases (Column 3) by the inpatient CMI (Column 6). The inpatient CMI is adjusted by the "CMI Adjustment Factor" (CMIAF) in Column 8 to account for the fact that the overall statewide CMI for the hospital entities included in the ROC do not equal to one. This is because in the creation of statewide casemix, weights for all the hospital entities are used; however, in the ROC, the oncology centers at Johns Hopkins Hospital, University of Maryland Medical System, and Sinai Hospital are excluded. For the CCT and CMI to be accurately blended, CMIAF has to be calculated. Column 9 then is the hospital's adjusted inpatient casemix weight.

The second set of calculations involves the hospital's outpatient revenue and outpatient casemix weight under the Charge per Visit System. The outpatient revenue, Column 13, is calculated by multiplying the hospital's outpatient visits (Column 10) by the CPV (Column 11). In order to calculate the hospital's outpatient casemix weight, the outpatient visits will have to be restated or redefined in relation to inpatient cases. This is done in Column 12 by multiplying the hospital's outpatient visits (Column 10) by the "Outpatient Visit Standardizing Factor" (OVSF), which is, simply, the Statewide Average CPV divided by the Statewide Average CPC. The outpatient casemix weight, Column 15, is calculated by multiplying the hospital's adjusted outpatient visits (Column 12) by the outpatient CMI (Column 14).

The final set of calculations involves the hospital's total revenue and total weight, EIPC, CCT, and CMI. The total revenue, Column 16, is calculated by adding the hospital's inpatient revenue (Column 5) to the outpatient revenue (Column 13). The EIPC, Column 17, is calculated by adding the hospital's inpatient cases (Column 3) to the adjusted outpatient visit (Column 12). The total weight, Column 18, is calculated by adding the hospital's adjusted inpatient casemix weight (Column 9) to the outpatient casemix weight (Column 15). The overall CMI, Column 19, is calculated by dividing the hospital's total weight (Column 18) by the EIPC (Column 17). Finally, the CCT, Column 20, is calculated by dividing the hospital's total revenue (Column 16) by the EIPC (Column 17).

Maryland Health Services Cost Review Commission

Additional data elements to be collected with the inpatient/outpatient hospital discharge data beginning July 1, 2009:

Inpatient:

1. Attending Physician NPI – Type 4 record at position 155-164

2. Operating Physician NPI – Type 4 record at position 165-174

3. Units and charges by rate center – in the current data layout of the Type 3 record, the 'Units of Service' field is a 7-digit field. Use first 3 positions for the 3 character rate center designation and use the last 4 digits for the units of service associated with the rate center.

Outpatient:

1. Operating Physician NPI – Type 1 record at 272-281

2. Reserve flag for clinic surgery and plastic surgery – Type 1 record at position 271
   "C" = clinic surgery
   "P" = plastic/cosmetic surgery
   "G" = Greenbaum Cancer Center
   "S" = UMMS Shock Trauma

3. Units and charges by rate center – in the current data layout of the Type 2 record, the 'Units of Service' field is a 7-digit field. Use first 3 positions for the 3 character rate center designation and use the last 4 digits for the units of service associated with the rate center.

4. Revised instructions for coding item # 48, Encounter Type:

   The encounter type for the visit is defined by type of rate center charge in the following order of priority:

   If record includes an OR charge (OR) or an OR clinic charge (ORC), then Encounter Type = Ambulatory Surgery = 04

   If record includes an ED charge (EMG), then Encounter Type = Emergency Room = 02

   If record includes a clinic charge (CL) then Encounter Type = Clinic = 01

   If record includes a labor and delivery charge (DEL) then Encounter Type = Labor & Delivery = 03

   All others = Other Outpatient = 05

5. Revised instructions for item # 39, Number of Visits/Ecounters:
   If this claim is a "series account" where claim remains open for recurring visits (HSCRC definition: difference between the "from date" and the "through date" is greater than 14 days), then enter the number of visits included in the claim. For all other claims, enter 1. Do not leave blank or enter 0.

Please send comments to Charlotte Thompson (cthompson@hscrc.state.md.us) by February 13, 2009

Staff Recommendation

Request by the Medical Assistance Program to Suspend Re-calculation
Current Financing Deposits

January 14, 2009

Introduction

The Medical Assistance Program (MAP) has been providing working capital advance monies (current financing) to hospitals to avail themselves of the prompt payment discount for many years. MAP is unique among third-party payers in that it is a governmentally funded program that covers qualified poor residents of Maryland. As such, it deals, to a large extent, with retro-active coverage. Recognizing the uniqueness of MAP, the Commission allowed MAP to negotiate a formula with the hospital industry to calculate its fair share of current financing monies. The Commission approved this alternative method of calculating current financing at its February 1, 1995 public meeting. Currently, MAP has approximately $85 million in current financing on deposit with Maryland hospitals.

MAP's Request

Because of the current budget crisis, on December 19, 2008, MAP submitted a request, attached, that the Commission approve an exception to the requirement that the amount of current financing on deposit with hospitals be re-calculated annually. The calculation for FY 2009 would increase hospitals' current financing deposits by approximately $11 million. MAP requests that for one year, FY 2009, the amount of current financing monies on deposit with Maryland for FY 2008 remain unchanged. In its request, MAP states that it intends to re-institute the annual re-calculation of current financing for FY 2010.

Staff Recommendation

After taking into account the current condition of the economy and its effect on MAP's budget, staff recommends that the Commission approve MAP's request that the current financing it has on deposit with Maryland hospitals remain unchanged and not be not be adjusted to reflect actual FY 2008 experience for one year, FY 2009.

STATE OF MARYLAND
DHMH

Maryland Department of Health and Mental Hygiene
201 W. Preston Street • Baltimore, Maryland 21201
Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – John M. Colmers, Secretary

MEMORANDUM

To: Dennis Phelps, Associate Director, Audit and Compliance
Health Services Cost Review Commission (HSCRC)

From: John Folkemer, Deputy Secretary
Health Care Financing

Date: December 19, 2008

Subject: Working Capital Advances

This memo is to request the approval by the HSCRC of an exception in the requirement to update the current financing on deposit with the hospitals on an annual basis. Due to the fiscal condition of the State, the Department requested at a meeting on December 9 with the Maryland Hospital Association (MHA) that MHA support the Department's decision to forego the calculation for Fiscal Year (FY) 09. The hospitals are not receiving an additional $11 million. The Department intends to re-institute the calculation in FY 10 beginning with FY 08.

We appreciate your support with this issue and are willing to discuss this at a Commission meeting if necessary. Please let me know if we need to do anything else.

cc: John Colmers
Robert Murray
Audrey Parham-Stewart

Staff Recommendation

Kennedy Krieger Institute Reporting Requirements

January 14, 2009

Introduction and Background

The Health Services Cost Review Commission has jurisdiction over hospital services offered by or through all facilities in the State of Maryland. At its July 1, 1974 public meeting, the Commission voted to exempt the Kennedy Krieger Institute from Commission rate setting. The chief reason the Hospital was granted the exemption was because of its unique funding sources, i.e., an unusually large percentage of its revenue was provided by grants, endowments, and governmental payers who were not required to pay Commission approved rates. When the exemption was granted, Kennedy Krieger was not required to file any financial reports.

Staff Recommendation

Staff believes that it is appropriate that the Commission be aware of the financial position of all hospitals under its jurisdiction, including Kennedy Krieger. In addition, staff believes that Kennedy Krieger should be required to provide evidence that its sources of revenue continue to justify its exemption from Commission rate-setting.

Therefore, staff recommends that the Kennedy Krieger Institute be required to: 1) immediately file audited financial statements for its most recent fiscal year; 2) submit the applicable schedules from its most recent Medicare Cost Report or other appropriate documentation, subject to the approval of staff, which discloses its sources of gross patient revenue for its most recent fiscal year; and 3) annually, 120 days after the end of its fiscal year, provide audited financial statements and documentation to justify its continued exemption from Commission rate setting.

Title 10 DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Subtitle 37 HEALTH SERVICES COST REVIEW COMMISSION

10.37.10 Rate Application and Approval Procedures

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

NOTICE OF PROPOSED ACTION

The Health Services Cost Review Commission proposes to amend **Regulation .26B** under **COMAR 10.37.10 Rate Application and Approval Procedures.** This action was considered and approved for promulgation by the Commission at a previously announced open meeting held on January 14, 2009, notice of which was given pursuant to State Government Article, §10-506(c). Annotated Code of Maryland. If adopted, the proposed amendments will become effective on or about May 4, 2009.

Statement of Purpose

The purpose of this action is to change the interest or late payment charges that a hospital may add to a bill to those payers and self-paying patients not subject to the prompt payment claims provision of the Insurance Article.

Comparison of Federal Standards

There is no corresponding federal standard to this proposed action.

Estimate of Economic Impact

Please see the attached Economic Impact Statement.

Opportunity for Public Comment

Comments may be sent to Diana M. Kemp, Regulations Coordinator, Health Services Cost Review Commission, 4160 Patterson Avenue, Baltimore, Maryland 21215, or call (410)

764-2576, or fax to (410) 358-6217, or email to dkemp@hscrc.state.md.us. The Health Services Cost Review Commission will consider comments on the proposed amendments until March 13, 2009. A hearing may be held at the discretion of the Commission.

.26 Differentials

B. Working Capital Differentials – Payment of Charges.

(1)-(2) Text Unchanged.

(3) A payer or self-paying patient who does not provide current financing under § B(1)(a)-(e) of this regulation shall receive a 2-percent discount if payment is made at the earlier of the end of each regular billing period or upon discharge from the hospital. Payment within 30 days of the earlier of the end of each regular billing period or discharge entitles a payer or self-pay patient to a 1-percent discount. For those payers and self-paying patients not [generally] subject to **the prompt payment of claims provision of** the Insurance Article, **§ 15-1005,** Annotated Code of Maryland, after 60 days from the date of the earlier of the end of each regular billing period or discharge, interest or late payment charges may accrue on any unpaid charges at **an annualized interest charge of no more than 3 percentage points above the most recent (i.e., at the time of billing) average prime rate of interest, as published in the "*Money Rates*" section of the *Wall Street Journal*, on the unpaid balance**. [a simple rate of 1 percent per month.] The interest or late payments charges may be added to the charge on the 61st day after the date of the earlier of the end of each regular billing period or discharge and every 30 days after that.

(4) Hospital Billing Responsibilities.

(a)-(b) Text Unchanged.

(c) The bill land the notice shall state that the:

(i) Charge is due within 60 days of the discharge or dismissal; and

(ii) Patient shall receive a 2-percent discount by paying upon discharge or a 1-percent discount by paying within 30 days; and

(iii) Payment may be subject to interest or late payment charges at [a rate of 1-percent per month] **an annualized interest charge of no more than 3 percentage points above the most recent (i.e., at the time of billing) average prime rate of interest, as published in the "*Money Rates*" section of the *Wall Street Journal*, on the unpaid balance** beginning on the 61st day after the date of the earlier of the

end of each regular billing period or discharge and every 30 days after that.

(5) Text unchanged.

C. Text unchanged.

DONALD A. YOUNG, MD
Chairman
Health Services Cost Review Commission

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

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HEALTH SERVICES COST REVIEW COMMISSION
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Toll Free 888-287-3229
Web Site: http://www.hscrc.state.md.us/

TO: Commissioners

FROM: Legal Department

DATE: January 9, 2009

SUBJECT: Hearing and Meeting Schedule

Public Session

February 4, 2009	Time to be determined, 4160 Patterson Avenue, HSCRC Conference Room
March 4, 2009	Time to be determined, 4160 Patterson Avenue, HSCRC Conference Room

Please note, Commissioner packets will be available in Commission offices at 8:00 a.m.

The agenda for the Executive and Public Sessions will be available for your review on the Commission's Web Site, on the Monday before the Commission Meeting. To review the agenda, visit the Commission's web site at http://www.hscrc.state.md.us