STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

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469th MEETING OF THE HEALTH SERVICES COST REVIEW COMMISSION

July 7, 2010

PUBLIC SESSION

9:00 a.m.

1. **Review of the Public Minutes of June 9, 2010**
2. **Executive Director's Report**
3. **Docket Status - Cases Closed**

   2068A - University of Maryland Medical Center
   2069A - University of Maryland Medical Center
   2070A - University of Maryland Medical Center
   2072R - Suburban Hospital

4. **Docket Status - Cases Open**

   2071N - James Lawrence Kernan Hospital
   2073A - University of Maryland Medical Center
   2074A - MedStar Health
   2075A - Johns Hopkins Health System
   2076R - St. Agnes Hospital

5. **Final Recommendation on FY 2011 Update to Hospital Rates**
6. **Report on the Results of the Uncompensated Care Policy**
7. **Legal Report**
8. **Hearing and Meeting Schedule**

IN RE: THE PARTIAL RATE	*	**BEFORE THE HEALTH SERVICES**
APPLICATION OF THE	*	**COST REVIEW COMMISSION**
JAMES LAWRENCE	*	**DOCKET 2010**
KERNAN HOSPITAL	*	**FOLIO: 1881**
BALTIMORE, MARYLAND	*	**PROCEEDING: 2071N**

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Staff Recommendation

July 7, 2010

Introduction

On May 12, 2010, James Lawrence Kernan Hospital (the Hospital) submitted a partial rate application to the Commission requesting a rate for Interventional Cardiovascular (IRC) services. The Hospital is requesting the statewide median rate for IRC services to be effective June 1, 2010.

Staff Evaluation

To determine if the Hospital's IRC rate should be set at the statewide median rate or at a rate based on its own cost experience, the staff requested that the Hospital submit to the Commission all cost and statistical data for IRC services for FY 2011. Based on information received, it was determined that the IRC rate based on the Hospital's actual data would be $ 33.46 per RVU, while the statewide median rate for IRC services is $53.78 per RVU.

Recommendation

After reviewing the Hospital's application, the staff recommends as follows:

1. That COMAR 10.37.10.07 requiring that rate applications be filed 60 days before the opening of a new service be waived;
2. That an IRC rate of $33.46 per RVU be approved effective July 1, 2010;
3. That no change be made to the Hospital s Charge per Case standard for IRC services; and
4. That the IRC rate not be rate realigned until a full year's experience data have been reported to the Commission.

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IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION	*	**COMMISSION**	
MEDSTAR HEALTH	*	**DOCKET:**	**2010**
BALTIMORE, MARYLAND	*	**FOLIO:**	**1884**
	*	**PROCEEDING:**	**2074A**

Staff Recommendation

July 7, 2010

I. INTRODUCTION

MedStar Health filed an application with the HSCRC on June 21, 2010 on behalf of Union Memorial Hospital and Good Samaritan Hospital (the "Hospitals") for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. Medstar Health requests approval from the HSCRC for continued participation in a global rate arrangement for cardiovascular services with the Kaiser Foundation Health Plan of the Mid-Atlantic, Inc. for a period of one year beginning August 1, 2010.

II. OVERVIEW OF APPLICATION

The contract will continue to be held and administered by Helix Resources Management, Inc. (HRMI). HRMI will manage all financial transactions related to the global price contract including payments to the Hospitals and bear all risk relating to services associated with the contract.

III. FEE DEVELOPMENT

The hospital portion of the global rates was renegotiated in 2007. The remainder of the global rate is comprised of physician service costs. Also in 2007, additional per diem payments were negotiated for cases that exceed the outlier threshold.

IV. IDENTIFICATION AND ASSESSMENT OF RISK

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

V. STAFF EVALUATION

The staff reviewed the results of last year's experience under this arrangement and found that they were favorable. Staff believes that the Hospitals can continue to achieve a favorable experience under this arrangement.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' request for continued participation in the alternative method of rate determination for cardiovascular services for a one year period commencing August 1, 2010. The Hospitals will need to file a renewal application for review to be considered for continued participation.

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

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION	*	**COMMISSION**	
JOHNS HOPKINS HEALTH	*	**DOCKET:**	**2010**
SYSTEM	*	**FOLIO:**	**1885**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2075A**

Staff Recommendation

July 7, 2010

I. INTRODUCTION

On June 21, 2010, 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 continue participation in global rates for cardiovascular procedures with the Canadian Medical Network. The Hospitals request that the Commission approve the arrangement for an additional year beginning effective July 1, 2010.

II. OVERVIEW OF APPLICATION

The contract will continue to be held and administered by Johns Hopkins HealthCare, LLC ("JHHC"), which is a subsidiary of the System. JHHC will continue to 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 continue to submit bills to JHHC for all contracted and covered services. JHHC is responsible for billing the payer, collecting payments, disbursing payments to the Hospitals at their full HSCRC approved rates, and reimbursing the physicians. The System contends that the arrangement among JHHC, the Hospitals, and the physicians holds the Hospitals harmless from any shortfalls in payment from the global price contract. JHHC

maintains it has been active in similar types of fixed fee contracts for several years, and that JHHC is adequately capitalized to bear the risk of potential losses.

V. STAFF EVALUATION

Staff finds that the actual experience under the arrangement for the last year has been favorable. The hospital component of the global prices and the contract terms have been updated based on current data, and staff is satisfied that the Hospitals can continue 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 one year beginning July 1, 2010. The Hospitals must file a renewal application annually for continued participation.

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

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Memorandum

To: HSCRC Commissioners

From: Robert Murray

RE: FY 2011 Hospital Payment Update Proposals

Date: June 30, 2010

Included in this packet, please find the original staff recommendation on the FY 2011 hospital payment update as well as a letter outlining a proposal by the Maryland Hospital Association (MHA) and payer representatives for an alternative update option.

Staff is meeting with MHA and payer representatives to better understand their proposal and will provide an analysis of the proposal prior to the Commission meeting on July 7, 2010.

June 22, 2010

Donald A. Young, M.D.
Chairman
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215-2299

Dear Dr. Young:

As key stakeholders in the Maryland rate setting process, we are writing to share with the Commission that, after devoting much time and effort, we have developed a joint consensus proposal for the FY 2011 hospital payment update for the Commission's consideration. Because of the late date in the Commission's decision making process, we respectfully request that you delay your scheduled decision to the July 7, 2010 Commission meeting in order to allow time for us to share the proposal in more detail and for all parties involved to better understand its implications.

We believe this joint consensus proposal does several important things: 1) provides incentives for hospitals to reduce unnecessary use of services; 2) focuses on reducing readmissions in a way that complements the work of the Commission that will be implemented later this year; and 3) acknowledges that reducing readmissions is a multi-stakeholder effort. Moreover, the spirit of this joint consensus proposal and all of the collaborative work that led to it is critical to the important task that lies ahead for all of us – reshaping Maryland's all-payor rate-setting system. That will be a complex task. The spirit in which we have reached consensus on this update proposal for FY 2011 is critical to our collective working relationship as we move forward together on reform.

As you know from Commission staff presentations, the potential for significant system savings through reductions in readmissions is clear. In reaching consensus, the parties have agreed to an update that will provide hospitals with an incentive to achieve a specific level of reduction in readmissions in 2011, with a portion of that amount to be returned in 2012 if hospitals fail to achieve the agreed-upon target.

The specifics of the consensus proposal are as follows:

- A total update of 2.44 percent, of which 0.44 percentage points are specifically targeted to fund readmission reduction programs to be implemented in Maryland hospitals through efforts coordinated by the Maryland Hospital Association (MHA).

- A goal of a 10 percent reduction in readmissions to be achieved in the fourth quarter (April 1 through June 30, 2011) across all Maryland hospitals. The methodology to be used to calculate this goal would be agreed to by the HSCRC, payors and MHA by September 1, 2010. The HSCRC would serve as the entity measuring the results achieved. Measurement would occur after June 30, 2011 and before September 1, 2011.

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- Hospitals and MHA would define and implement any program design they believe best achieves the goal; payors believe that Project RED is most promising.

- The Medicaid program would be held harmless for any impact of this update beyond what the state has budgeted for the update for FY 2011. Hospitals would pay 100 percent of that added cost through an increase to their Medicaid assessment.

- Failure to achieve the goal would result in a 0.22 percentage point reduction in the update factor to be set by the HSCRC for July 1, 2011 through June 30, 2012 rates.

- This consensus proposal would be in effect for one year.

We are pleased to present this framework to the Commission for your consideration. After spending many hours together working on an update factor, we are only asking the Commission to delay making its decision on the update until July 7, an update that would still be applied to July 1 hospital rates. Assuming you agree to delay your decision until July 7, this letter will be followed by a more detailed description of the consensus proposal and what we believe we can achieve working together. We look forward to working with Commission staff in the interim to fully brief them on our discussions and enhance their understanding of this framework. We join together in urging that the Commission consider and adopt this proposal for FY 2011.

If you have any questions, please feel free to contact any one of us.

Sincerely,

John M. Colmers
Secretary, Department of
Health and Mental Hygiene

Chet Burrell
President and CEO
CareFirst BlueCross BlueShield

Dennis P. O'Brien
Regional Vice President
Northeast Network Management
UnitedHealthcare

Carmela Coyle
President & CEO
Maryland Hospital Association

cc: C. James Lowthers
Commissioner, HSCRC

Trudy Hall, M.D.
Commissioner, HSCRC

Kevin J. Sexton
Commissioner, HSCRC

Joseph Antos, Ph.D.
Commissioner, HSCRC

Steven Larsen, J.D.
Commissioner, HSCRC

Herbert S. Wong, Ph.D.
Commissioner, HSCRC

Robert Murray
Executive Director, HSCRC

Final Staff Recommendation and Discussion Document Regarding the FY 2011 HSCRC Hospital Payment Update

Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215
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June 24, 2010

This document represents a final recommendation to be presented to the Commission on June 24, 2010 to be presented to the Commission for final action. Comments should be sent to Robert Murray, Executive Director, HSCRC 4160 Patterson Avenue, Baltimore MD 21215.

Background

Payment Update Discussions

Each year, the HSCRC convenes a Work Group consisting of HSCRC staff and representatives from the payer and hospital industries to assist the Commission in the development of the annual update to Maryland hospital rates and approved Charge per Case (CPC) and Charge per Visit (CPV) targets. These deliberations have usually resulted in a proposal for a "rate arrangement" with parameters and criteria that govern the development of annual updates for a three year time frame.

Since the Commission's "Redesign" of the rate setting system in FY 2000, the Commission has generally favored the adoption of rate arrangements covering three year time periods. Three year arrangements were approved for the periods FY 2001-2003, FY 2004-2006, and FY 2007 – FY 2009. These arrangements specify the basic parameters and/or formulaic approach that determine the update factor for each year of the arrangement. Multi-year rate update arrangement define the general trajectory of hospital rates over three years (e.g., the FY 2004-2006 rate arrangement was structured to provide hospitals with significant additional funds to help build profitability and facilitate hospital recapitalization). As such, these multi-year arrangements can be designed to achieve medium-term policy objectives of the Commission and, at the same time, provide a higher degree of predictability for hospitals and payers for financial management and budgeting purposes.

FY 2010 Rate Update Structure: The approved update for FY 2010 was an exception to the Commission's desire to adopt three-year rate arrangements. In FY 2010, the Commission adopted a rate arrangement that applied to only one year given the uncertainty associated with general economic conditions.

Because of uncertainty regarding the impact of national health reform and the uncertain course of the current economic recovery all parties are in agreement that the Commission should only consider a rate update proposal for one year only (increase to rates, CPC and CPVs for FY 2011, effective July 1, 2010).

Annual Rate Update Mechanism – Policy Implications

The HSCRC annual rate update is an important policy tool for the Commission and has implications for such important policy considerations as: 1) the affordability of hospital care in the State; 2) the financial condition and viability of the Maryland hospital industry; and 3) the overall long-term longevity of the rate setting system.

Cost Containment Tool: Since the inception of rate setting in Maryland, the HSCRC has structured its annual rate update mechanism to meet predefined policy objectives related to cost containment and the financial condition of the industry. In the early years of rate setting, the system was structured to provide hospitals with updates sufficient to cover factor cost inflation (the rate of growth of inputs to the hospital production process) plus 1% in Maryland at a time when U.S. hospitals' per case revenues were growing at factor cost inflation plus 2 to 3%. Over this period, Maryland payment levels and costs per case grew more slowly than payments and costs nationally. This dynamic contributed to the generation of considerable cost savings to the State in the form of averted hospital spending (estimated to be in excess of $42 billion over the period 1976 to 2008).

Medicare Waiver Impact: The HSCRC's update factor policy also has considerable influence over the State's performance on the Medicare "Waiver Test" (the financial test the State must pass to keep its waiver for national Medicare and Medicaid reimbursement rules). Under the relatively restrictive updates provided for FYs 2001-2003, Maryland significantly improved its performance on the Waiver Test, moving from a position of a 15% relative cushion to an over 18% relative cushion over this period. Conversely, the next three year rate arrangement (FYs 2004 – 2006) contributed to a large erosion in the relative waiver position (from 18% to 11%).

Affordability Impacts: The magnitude of the HSCRC's annual hospital rate update also has significant implications for the affordability of hospital care within the State. Each 1.0% additional increment in the update represents approximately $136 million in annual hospital payments. The approved update factor also has a significant impact on the State budget. The Maryland Medicaid and State Employee Benefits programs respectively account for approximately 17% and 3% of the hospital expenditures. Thus, every 1.0% increase in the annual update will increase State hospital payments by approximately $13 million. The recent expansion of Medicaid eligibility, along with the impact of the recent economic downturn, have contributed to rapid growth in Medicaid enrollment. As of December 2009, Medicaid enrollment has increased at an annual growth rate of nearly 20% (enrollment increased from just over 500,000 recipients as of the end of fiscal year 2008 to an estimated 700,000 recipients year end fiscal 2010. Thus, hospital rate increases have a large impact on the State budget by way of increases in Medicaid and State Employee Benefit Program payments. Hospital payments (and thus the revenues hospitals generate) are also influenced by changes in the volume of services year to year.

Impacts on Hospital Financial Condition: Finally, the magnitude of the HSCRC annual update can also have significant impact on the financial condition of the Maryland hospital industry. During the period of less restrictive rate updates, FY 2004-FY 2009, hospital regulated operating profits increased from 3.5% to 5.8%. The relationship between rate updates and profitability is also influenced by the ability of hospital managers to improve efficiency in the face of constrained revenues. Medpac (the federal Commission that advises Congress on Medicare payment policy) observed that hospitals facing broad financial constraint from both public and private sector payers tend to have much lower costs than hospitals that tend to have high private payer margins and, thus, less broad-based financial pressure. Their overall conclusion is that revenue levels and constrained revenue levels tend to drive cost performance of the industry.

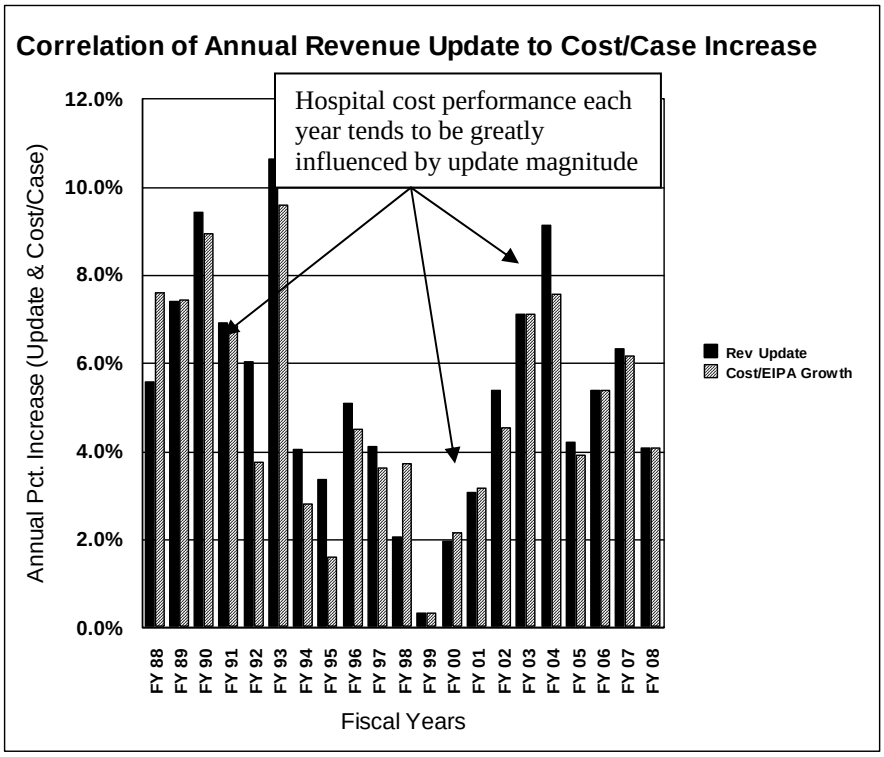
This observation is consistent with HSCRC staff observation that hospitals that face more stringent and broad based constraint tend to reduce costs more effectively. When the HSCRC has provided more restricted inflation updates, operating efficiency and cost performance has improved. When the HSCRC has been more generous in its update factors year-to-year, hospital cost spending increases. This observation is strongly supported by actual year-to-year payment vs. cost experience in Maryland. **Table 1** and **Chart 1** show the year-to-year relationship between approved revenue increases and the resulting hospital expenditure growth over the period 1988 -2008.

Table 1
Correlation of Annual Update to Eventual Cost per Case Growth

	Rev Update	Cost/EIPA Growth
FY 88	5.59%	7.60%
FY 89	7.42%	7.44%
FY 90	9.44%	8.94%
FY 91	6.93%	6.86%
FY 92	6.05%	3.77%
FY 93	10.66%	9.61%
FY 94	4.06%	2.81%
FY 95	3.39%	1.63%
FY 96	5.09%	4.52%
FY 97	4.13%	3.65%
FY 98	2.08%	3.74%
FY 99	0.35%	0.34%
FY 00	1.97%	2.18%
FY 01	3.09%	3.17%
FY 02	5.41%	4.56%
FY 03	7.13%	7.11%
FY 04	9.14%	7.57%
FY 05	4.21%	3.93%
FY 06	5.39%	5.39%
FY 07	6.33%	6.18%
FY 08	4.08%	4.08%

Most hospitals budget their expenses based on their expected income, just as most people do. If revenues are expected to go down, they will reduce their expenditures; if, on the other hand, revenues are expected to increase, they will allow costs to increase accordingly. This can be seen in the following chart, which shows expenses and net patient revenue per EIPA tracking very closely for the period 1988 to 2008. The correlation coefficient between the expense and net patient revenue per EIPA is 0.999. This analysis strongly support Medpac's conclusion in the March 2009 Report to Congress noted above, that revenues drive costs. As pressure is placed on the revenue curve facing the hospital industry, the behavioral response has and will be to improve efficiency.

Chart 1
Hospital Cost Growth Tends to Track Annual Rate Updates



FY 2011 Update Process

Payment Work Group: In November of this fiscal year, the staff assembled a "Payment Workgroup" to assist staff in the development of a draft recommendation for an inflation update to hospital rates for FY 2011 (effective July 1, 2010). This Workgroup consisted of representatives of HSCRC, staff, the Maryland Hospital Association (MHA) and individual hospitals, and public and private payers (including representatives from CareFirst of Maryland, Kaiser-Permanente, United Health Care, Amerigroup, Maryland Medicaid, and the State Employee Benefit Program). The goal of this effort was to assist the staff and the HSCRC in the determination of the most appropriate magnitude, structure and duration for updates to hospital rates, CPCs and CPVs.

Request of HSCRC Chairman and Update Structure: In response to a request by the HSCRC Chairman, staff solicited one-year and three-year rate proposals from both the hospital and payer representatives on the Payment Work Group. Staff also requested that the proposals follow the general Update structure and key components used by the Commission since FY 2001. **Table 2** illustrates the Commission's Update

Structure and key components as reflected in the HSCRC's approved FY 2010 Update. These components are also described below:

Table 2
HSCRC Approved FY 2010 Update

Market Basket (per Global Insights)	1.59%	
Forecasting Error	NA	
HSCRC "Policy Adjustment"	-0.10%	
Base Update	1.49%	Note 1
Case Mix Allowance	0.50%	
Base Update Plus Case Mix	1.99%	
Estimated Rate Year 2009 Volume Adjustment	-0.22%	
Estimated System-wide Update	1.77%	

Notes:
1) One third of base update, or 0.4967%, will be scaled for ROC purposes.
Also, 0.5% will be used to determine adjustment for Quality Based Reimbursement.

Key Components of the Update Factor

1- **Market Basket (MB):** The Market Basket is a fixed-weight index that measures price changes in the underlying factor inputs used in the hospital production process, as per HSCRC policy determined by Global Insight's 1st quarter book 2010 for the period July 1, 2010 – June 30, 2011 (and applicable time-period for a 3 year rate proposal). [1]

2- **Market Basket forecasting error**: An adjustment for historical trends in forecasting error by Global Insight. [2] The Commission has periodically included a factor to account for inflation forecasting errors over time. Forecasting errors are usually related to the inability to predict untoward catastrophic events such as the Iraqi war and hurricane Katrina. CMS does not include a forecast error in their hospital update.

3- **HSCRC Policy Adjustment**: In past years, the HSCRC Update has contained either a reduction to trend as a means of constraining revenue growth and hospital cost growth (productivity factor), or additions to trend to help improve the financial condition of the hospital industry.

[1] The market basket forecasts are developed on a quarterly basis by Global Insight Inc. (GI) under contract with the Center for Medicare and Medicaid Services (CMS). Updates to the market basket are available on a quarterly basis (lagged one quarter) with historical data also being updated at this time. Global Insight Inc. is a respected economic forecasting firm with the detailed macroeconomic and industry knowledge and expertise needed to forecast the price series used in the market basket. The forecasts are available for a 10-year period.

[2] Because many of the current payment systems adjust payments on a prospective basis, the market basket increases used in those updates are a forecast of what those increases will be. The actual market basket increase for a given period can be higher or lower than the forecasted increase available at the time a payment update is determined. This phenomenon is commonly known as forecast error. For example, in the spring of 2010, the HSCRC was required to forecast the market basket increase for fiscal year 2011. The actual change in the market basket for FY 2011 may be higher or lower than what we forecasted in the spring of 2010 depending on market conditions.

4- **Rate "Slippage"**: This component is an estimate of deviations from approved revenue growth as a result of other features of the rate setting system – such as rate increases granted individual hospitals, the impact of "Spend-down" agreements, or other factors.

5- **Case mix Allowance:** An allowance or limit on annual increases in measured additional resource use due to increase in measured patient severity of illness. Case mix allowances can apply to both inpatient and outpatient services.

6- **Volume Adjustment**: Commission policy regarding recognition of fixed and variable components of hospital cost. Current Commission policy is to recognize hospital costs as 85% variable.

Additional Adjustments: Current HSCRC policy also calls for the revenue neutral scaling of hospital position on the approved Reasonableness of Charges (ROC) comparison and allocation of rewards and penalties related to performance on the HCSRC's Quality-Based Reimbursement (QBR) and Maryland Hospital Acquired Conditions (MHAC) initiatives. The term "scaling" refers to the differential allocation of a pre-determined portion of base hospital revenue based on a distribution of hospital performance related to either relative efficiency or relative quality. This allocation is performed on a "revenue neutral" basis for the system as a whole. This means that the net increases in rates for to better performing hospitals is funded entirely by net decreases in rates for poorer performing hospitals.

In addition to information pertaining to the elements of both a 1-year and a 3-year update, the Commission staff requested that the submitted proposals also address each of the following questions/issues:

1 – **Scaling of ROC**: What magnitude (either dollar amount or percentage of approved revenue) should be devoted to the Commission's scaling based on hospitals' relative position on the FY 2010 ROC analysis;

2- **Scaling of Quality Initiatives**: What magnitude (either dollar amount or percentage of base revenue) should be devoted to the Commission's two quality initiatives (Quality-Based Reimbursement evidence based process measures and Maryland Hospital Acquired Conditions), and how should this magnitude be split between each initiative;

3 – **Specialty Hospital Update**: A proposed structure of the update applying to specialty (psychiatric, rehabilitation, and chronic) hospitals in the system (should it be the same or different from the overall FY 2011 update for the acute care hospitals);

4 –If a proposed 3-year arrangement is formula-based, parties were requested to provide a description of that formula and a list of all salient data sources used to calculate that formula.

5 – Other recommended action that might be related to the FY 2011 update factor.

Environmental Factors Impacting on Rate Update Decision

There are a number of environmental factors that the Work Group will be considering during its deliberations and negotiations regarding the FY 2011 Update factor. A discussion of these environmental factors both in this recommendation and during public deliberations before the HSCRC may be helpful to the Commission in its formulation of a motion and final action on the FY 2011 Update. The key environmental factors being considered are: 1) recent and current hospital financial performance; 2) recent and projected performance of the Rate Setting System on the Medicare Waiver Test; 3) the impact of the various Update Proposals in the context

of recommended FY 2011 cuts to Medicaid payments; and 4) the relative affordability and efficiency of Maryland hospitals vs. hospitals nationally.

Hospital Financial Performance: In general, the overall operating performance (both regulated operating profits and unregulated operating profits) of Maryland hospitals has improved over the period FY 2003 to FY 2009 (based on an analysis of 40 June Year End hospitals). Overall operating profits however, consist of profits from both regulated and unrelated lines of business. While regulated operating profits have experienced rapid improvements since FY 2003 (growing from 3.54% operating margin to 5.86% by 2009), annual increases in hospitals' unregulated losses have in-part offset the improved regulated service performance (**see Table 3**).

Overall operating margins did deteriorate slightly in FY 2008 and FY 2009 (relative to FY 2007), however this deterioration is completely attributable to an increase in unregulated losses (which is driven primarily by growing losses on physician subsidies and physician practices). Had unregulated losses (and physician losses) remained at FY 07 levels, overall operating margins in FY 09 would have improved to over 3.44% in FY 09.

Table 3
Maryland Hospital Operating Profits
Regulated/Unregulated and Total
FY 2003-2009

Operating Profits and Margins
Regulated, Unregulated, and Total

	Regulated	Unregulated	Total Operating	Physician Part B Losses	Physician Losses as Proportion of Total Unreg. Loss	Total Operating Profit holding Unregulated Loss Constant FY 2007
FY 2009						
Operating Profits	$582,261,100	($316,288,700)	$265,972,400	($263,690,200)	83.37%	$375,659,400
Operating Margins	5.86%	-32.88%	**2.44%**	-91.40%		**3.45%**
Includes 40 of 47 Total Hospitals (only June YE hospitals)						
FY 2008						
Operating Profits	$561,065,925	($290,264,092)	$270,801,833	($217,346,000)	74.88%	$334,144,633
Operating Margins	5.24%	-30.05%	**2.32%**	-83.67%		**2.86%**
FY 2007						
Operating Profits	$536,175,979	($207,068,523)	$329,107,456	($154,003,200)	74.37%	
Operating Margins	5.37%	-22.23%	3.02%	-65.26%		
FY 2006						
Operating Profits	$461,509,193	($188,139,753)	$273,369,440	($134,415,700)	71.44%	
Operating Margins	5.01%	-23.31%	2.73%	-63.68%		
FY 2005						
Operating Profits	$415,220,488	($146,099,505)	$269,120,983	($114,511,000)	78.38%	
Operating Margins	4.91%	-19.75%	2.93%	-62.14%		
FY 2004						
Operating Profits	$351,315,618	($149,658,021)	$201,657,597	($94,043,000)	62.84%	
Operating Margins	4.51%	-21.19%	2.37%	-54.86%		
FY 2003						
Operating Profits	$249,007,000	($131,180,600)	$117,826,400	($81,032,000)	61.77%	
Operating Margins	3.54%	-20.30%	1.54%	-60.46%		

Staff also examined year-to-date unaudited financials for 10 months ending April of FY 2010 vs. the same period in FY2009. Although unaudited data tend to closely track overall year-end performance – the allocation between regulated and unregulated revenues and expenses tends to be less accurately reported. The picture for FY 2010, however, seems to show steady overall financial performance by Maryland hospitals this year through January 2010, despite facing a very restrictive Update factor in FY 2010 (overall operating margins – both regulated and unregulated were 2.6% in FY 09 six months year-to-date, vs. 2.02% for the same period in FY 10). Operating performance for FY 2010 did drop considerably during the month of February however, in part

due to the impacts on volume of the severe snow storms that hit the State during that month. Another factor impacting hospitals negatively in the last half of FY 2010 is the application of the $27 million in direct remittances from hospitals to the State's General fund associated with Medicaid Budget cuts approved by the Budget and by the Board of Public Works in the fall of 2009.

Non-Operating Margins: FY 2010 is also characterized by some recovery in hospital non-operating income and liquidity position of hospitals (also see **Table 4**). While overall operating performance remained in FY 2009 (over 2008), hospitals (along with most other businesses) experienced large non-operating losses. These non-operating losses include both realized losses from investments (due largely to liquidated equity positions following the large declines in the equity market), unrealized losses from current investments, and large "mark-to-market" swap liabilities associated with interest rate swaps on the balance sheets of hospitals. The primary impact of these realized and unrealized losses in FY 09 was that they placed pressure on the liquidity position of hospitals in that: 1) investment declines directly reduce cash positions; and 2) unrealized losses related to swap arrangements trigger collateral calls (the requirement that hospitals post additional cash as collateral as the magnitude of swap liabilities increase). The partial recovery in the non-operating position of hospitals and the narrowing of rate spreads have reduced the collateral requirements for hospitals in FY 2010 and have mitigated some of the liquidity pressure experienced in the previous year.

Table 4 shows the comparison of year-to-date (YTD) performance July-April FY 2010 vs. July-April FY 2010 for operating, non-operating and total profits.

Table 4

Year to Date Overall Financial Performance – Maryland Hospitals

Acute Care Hospitals F/S Data

Unaudited Finanical Data

Regulated and Unregulated Services Combined

Comparison of April 2010 YTD results to April YTD 2009

	YTD April 2009	YTD April. 2010
Total Operating Profit	2.60%	2.02%
Non-Operating Profit	-4.16%	2.88%
Total Profit	-1.56%	4.90%

Rapidly Growing Losses on Physician-related Services: While the HSCRC rate setting policy (which largely determine regulated revenues) does substantially influence hospital financial condition, staff has noticed another dynamic that is increasingly (and negatively) affecting the overall financial condition of the hospital industry. This year, staff has begun a more thorough analysis of trends in unregulated operating performance since FY 2003. As reported previously, regulated operating margins have improved steadily from FY 2003 to 2009 (from 3.54% in FY 2003 to 5.8% in FY 2009), while unregulated operating losses have increased (from -20.8% to -33.9% respectively). Based on 10 months of data for FY 2010, it appears that the erosion in total operating profits (both regulated and unregulated) may in part be a function of continued increases in unregulated operating losses (particularly physician losses).

The **Table 5** and **Chart 2** below show that had hospitals held unregulated losses to FY 2003 – 2005 levels, overall operating profits would be well in excess of current desired levels. It is clear from these data that growing physician losses (not restricted rate increases) represent the primary reason for less desirable hospital operating performance in recent years. The chart below also shows that as regulated operating margins have increased over time, unregulated losses have eroded in a parallel fashion.

Table 5

Trends in Regulated Profits, Unregulated Losses (including physician losses) Total Profits

	Regulated	Unregulated	Total	Physicians
FY 03	$249,007,000	($131,180,600)	$117,826,400	($81,032,000)
FY 04	$351,315,618	($149,658,021)	$201,657,597	($94,043,000)
FY 05	$415,220,488	($146,099,505)	$269,120,983	($114,511,000)
FY 06	$461,509,193	($188,139,753)	$273,369,440	($134,415,700)
FY 07	$536,175,979	($207,068,523)	$329,107,456	($154,003,200)
FY 08	$561,065,925	($290,264,092)	$270,801,833	($217,346,000)
FY 09	$582,261,100	($316,288,700)	$265,972,400	($263,690,200)

Chart 2

Trends in Regulated Profits, Unregulated Losses (including physician losses) Total Profits

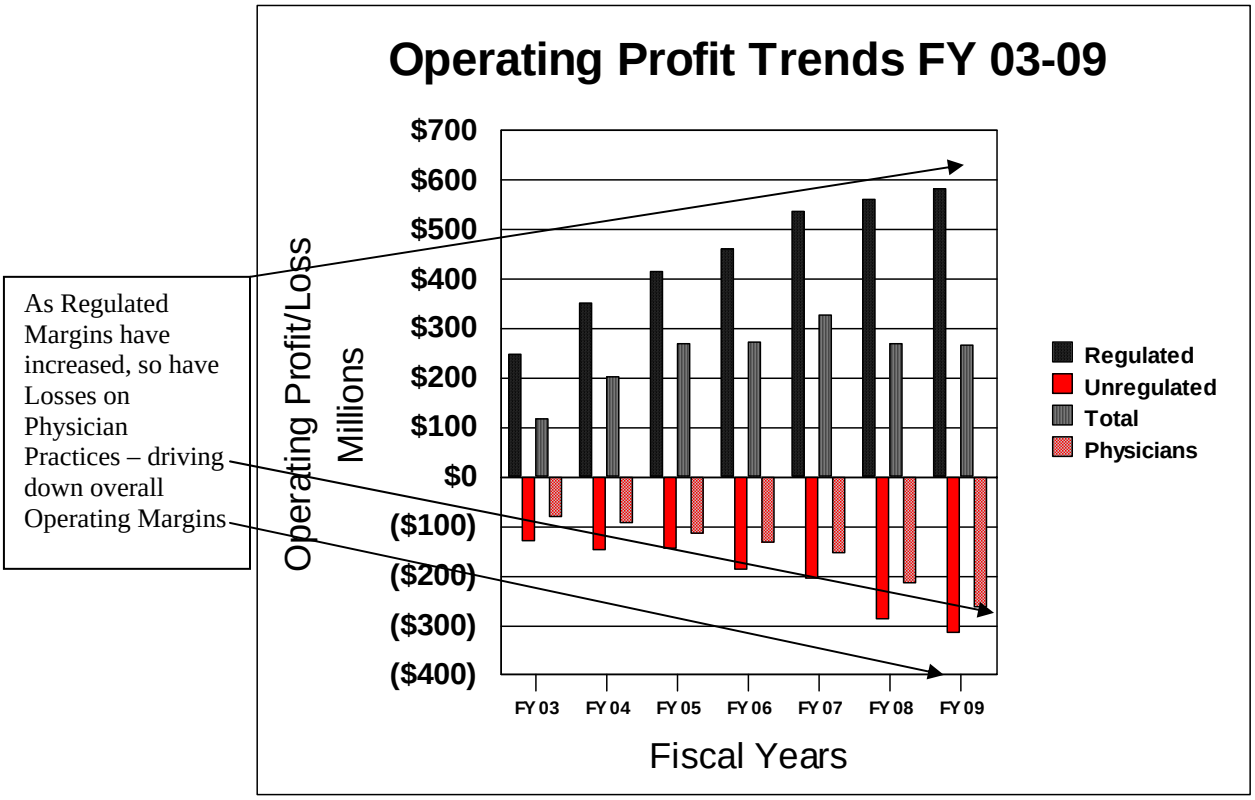


Table 6 on the following page – illustrates this negative impact in more detail and also attempts to estimate the regulated and unregulated profitability mix for the full rate year FY 2010. The Table also shows that hospitals' steady or declining total operating margins over the past eight years are, in large part, due to the persistent erosion of operating profitability attributed to growing unregulated losses – principally growing physician "part B" losses. While the HSCRC can monitor these trends in aggregate, the Commission currently does not collect detailed data on physician related losses. Staff is thus unable to determine whether these losses are related primarily to coverage and payer-mix issues or are a function of more strategic business decisions of hospital management. Staff is also unable to assess the reasonableness of these growing losses (either in aggregate or by hospital). It may well be that some hospitals (particularly those in inner-city environments) have no choice but to heavily subsidize physicians to provide services and provide coverage for hospital specialty care; however, staff also believes that some of these growing losses can likely be attributed to discretionary decision-making by hospital management, aimed at capturing and increasing patient volumes. Discretionary and strategically motivated decision-making of this nature should be the responsibility of the hospital, and regulated rates should not be increased to fund these types of activities.

Regulated/Unregulated Performance 2003- 2009 and Projected 2010

Column		A	B	C	D	E	F	G	H	I	J	K	L	M	N
line		Reg Revenue	Reg Expense	Reg Profits	Reg Op Margin	Unreg Rev	Unreg Exp	Unreg Profit	Unreg Profit %	Unreg. Profit %	Total Profits	**Total Op. Margin**	Physician Part B Rev	Physician Part B Exp	Part B Physic. Loss
1	Proj 2010	**$11,472,406,439**	$10,835,043,303	$637,363,135	5.56%	$1,133,330,828	$1,550,569,865	-$417,239,037	-36.82%	**-3.31%**	$220,124,098	**1.75%**	$323,409,918	-$643,001,931	-$319,592,013
2	2009	$11,278,814,403	$10,626,817,700	$651,996,703	5.78%	$1,046,295,634	$1,395,650,033	-$349,354,399	-33.39%	**-2.83%**	$302,642,304	**2.46%**	$289,847,400	-$553,881,900	-$264,034,500
3	2008	$10,704,338,397	$10,143,272,472	$561,065,925	5.24%	$965,944,389	$1,256,208,481	-$290,264,092	-30.05%	**-2.49%**	$270,801,833	**2.32%**	$259,767,900	-$477,113,900	-$217,346,000
4	2007	$9,982,901,465	$9,446,725,486	$536,175,979	5.37%	$931,397,459	$1,138,465,982	-$207,068,523	-22.23%	**-1.90%**	$329,107,456	**3.02%**	$235,973,300	-$389,976,500	-$154,003,200
5	2006	$9,203,751,936	$8,742,242,743	$461,509,193	5.01%	$807,268,702	$995,408,455	-$188,139,753	-23.31%	**-1.88%**	$273,369,440	**2.73%**	$211,071,400	-$345,487,100	-$134,415,700
6	2005	$8,460,040,439	$8,044,819,951	$415,220,488	4.91%	$739,646,635	$885,746,140	-$146,099,505	-19.75%	**-1.59%**	$269,120,983	**2.93%**	$184,288,300	-$298,799,300	-$114,511,000
7	2004	$7,787,586,634	$7,436,271,016	$351,315,618	4.51%	$706,133,300	$855,791,321	-$149,658,021	-21.19%	**-1.76%**	$201,657,597	**2.37%**	$171,423,800	-$265,466,800	-$94,043,000
8	2003	$7,027,991,900	$6,778,984,900	$249,007,000	3.54%	$646,110,200	$777,290,800	-$131,180,600	-20.30%	**-1.71%**	$117,826,400	**1.54%**	$134,027,600	-$215,059,600	-$81,032,000
	Scenarios Projected FY 2010 Operating Performance														
9	Projected	$11,472,406,439	$10,835,043,303	$637,363,135	5.56%	$1,133,330,828	$1,550,569,865	-$417,239,037	-36.82%	-3.31%	$220,124,098	**1.75%**	$323,409,918	-$643,001,931	-$319,592,013
10	Scenario 1	$11,472,406,439		$637,363,135		$1,133,330,828		-$378,415,141	-33.39%	-3.00%	$258,947,994	**2.05%**			
11	Scenario 2	$11,472,406,439		$637,363,135		$1,133,330,828		-$340,563,336	-30.05%	-2.70%	$296,799,799	**2.35%**			
12	Scenario 3	$11,472,406,439		$637,363,135		$1,133,330,828		-$242,051,131	-21.36%	-1.92%	$395,312,004	**3.14%**			
									Avg 03-07						
13	Expected Bad Debt Adjustment 2011											0.50%			

This theory that more hospitals are making strategic decisions to fund or subsidize physician activity to increase hospital volumes is further substantiated by an analysis (performed by staff) that shows that hospitals in non-inner city and non-rural areas (where coverage subsidies would likely be required to such a degree) consistently generate the largest proportions of physician-related Part B losses and account for the largest growth in these losses over time.

Staff believes that some of the erosion in overall operating profits from 2009 to 2010 is most likely a function of continued increases in physician Part B losses. Table 6 above shows the staff estimate for the full year FY 2010 based on 10 months of data through April 2010.

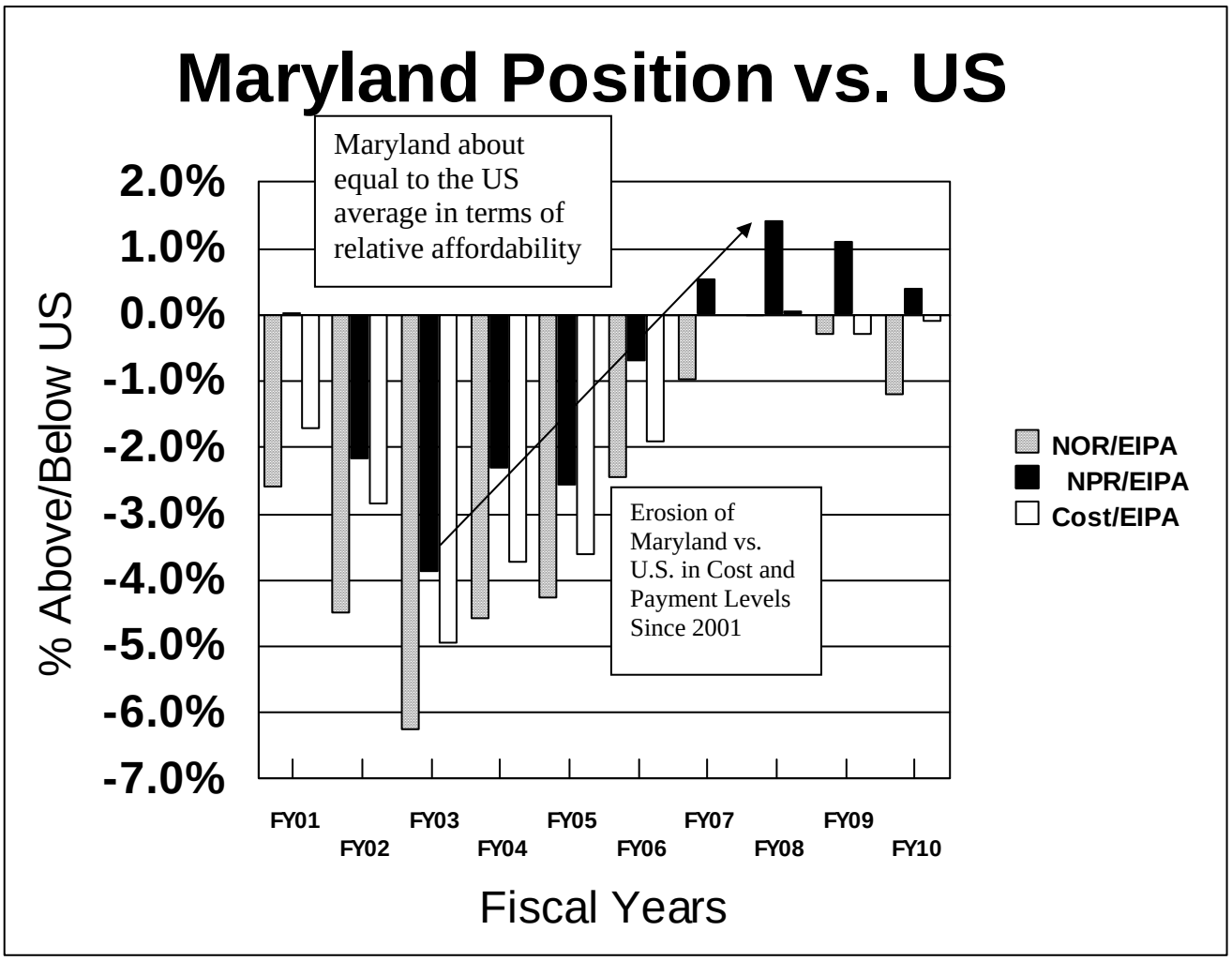
Relative Affordability of Hospital Care and Maryland's Cost Performance vs. the U.S.: General economic activity nationwide was in a state of "severe contraction" in FY 2009 with national GDP estimated to have declined significantly for much of FY 2009. While economic growth has started to recover, the severe economic downturn has pushed unemployment rates above 10% in recent months. This contraction has impacted virtually all sectors of the economy. The growing un-affordability of hospital services has been a large concern of the HSCRC in recent years. This recent contraction in economic activity means that health care services have become even less affordable. This dynamic is particularly pronounced in Maryland relative to the rest of the U.S. because hospital payments and costs have increased more rapidly here than in the rest of the country over the past 4-5 years. **Table 7 and Chart 3** below shows how Maryland hospital payment levels and costs have increased relative to hospital payment levels - Net Patient Revenue (NPR) and Net Operating Revenue (NOR) and hospital Costs nationally.

Table 7
Trends in the Relative Affordability of Maryland Hospital Care

Maryland Position vs. the US Hospital
Net Operating Revenue (NOR), Net Patient Revenue (NPR)
and Cost per Equivalent Inpatient Admission (EIPA)

	NOR/EIPA	NPR/EIPA	Cost/EIPA
FY01	-2.60%	0.03%	-1.72%
FY02	-4.51%	-2.18%	-2.86%
FY03	-6.27%	-3.88%	-4.97%
FY04	-4.59%	-2.32%	-3.76%
FY05	-4.28%	-2.58%	-3.65%
FY06	-2.46%	-0.71%	-1.92%
FY07	-0.99%	0.53%	-0.01%
FY08	-0.03%	1.42%	0.06%
FY09	-0.31%	1.11%	-0.31%
FY10	-1.21%	0.38%	-0.11%

Chart 3
Erosion of Maryland Hospital Payments and Costs vs. US Hospitals



Development of a Cost per EIPA Target for the Rate System

In response to a request by the Commission at the May 2010 public meeting, staff is proposing the Commission consider the adoption of a specific cost per adjusted admission target for the Maryland hospital industry. Currently, the Commission has as policy a target of being 3-6% below the national cost per adjusted admission level.

Exhibit I below provides an analysis and methodology used by staff for the proposed establishment of a goal of moving the hospital industry from a position of 0.21% below the US on Cost per EIPA (estimated FY 2010 position) to a position of 6.0% below the US on Cost per EIPA by FY 2015.

In reaching this policy target of 6.0% below the US, the staff used the following rationale:

1) the HSCRC's current policy is a range – to be 3-6% below the US on Cost per EIPA (although the system is currently only 0.21% below);

2) the Maryland system has historically been as low as 11-12% below the US on this measure (in the 1992-1993 period), so much lower levels of relative cost efficiency are achievable;

3) Medpac has demonstrated that the most efficient hospitals in the US (those facing broad financial constraint by both public and private payers) are currently about 9.0% below the US average cost per EIPA level;

4) Gradual improvement of approximately 1.25% per year relative to the US will help the system minimize an erosion of the Medicare waiver;

5) Improvement on an efficiency basis will result in improved relative affordability of hospital care in Maryland relative to the US, which will be vitally important in an era of massive health insurance expansion (other states such as Massachusetts, that have moved aggressively to expand access to health insurance without taking steps to improve system affordability, are in severe danger of not being able to sustain their access expansions);

6) Adopting a policy to improve vs. the nation in cost performance will require rate pressure. This rate pressure will provide stronger incentives for hospitals to reduce large and rapidly growing unregulated operating losses;

7) If the system underperforms and does not achieve the necessary year-to-year reductions – then the system will at least be moving in an appropriate direction, and the result will be consistent with current Commission policy (to be 3 to 6% below the US on Cost per EIPA).

It should be noted that both payer and hospital representatives believe that the EIPA calculation (which establishes a measure of hospital volume for outpatient services that is "equivalent" to inpatient volume on the basis of inpatient and outpatient revenue) contains distortions at a national level. Yet, payers and hospitals disagree on the direction of that distortion. The hospital representatives argue that high markups on hospital outpatient charges nationally result in artificially high EIPA counts, which make the US Cost per EIPA figure appear much lower than should actually be the case. Conversely, the Payer representatives believe that US hospitals mark up their inpatient charges more than they do their outpatient charges. This results in EIPAs being artificially understated. This would mean that Maryland's position vis-à-vis the US appears more favorable than is actually the case.

Staff does not believe it is possible to definitively confirm either theory. The staff proposal is merely advanced as a policy to improve from current levels vs. the nation. Doing so will help achieve the policy objectives stated above. Exhibit I below, provides a summary of the staff analysis.

Exhibit I

Current Estimate & Forecast NOR, NPR and Cost per EIPA: Maryland vs Nation

Procedural Steps

1 - Used AHA data for 2000-2008 period

2 - Error found in University of MD submission for 2008 - adjustments made to MD data

3 - For 2009 - draft AHA and Disclosure per EIPA increase does not reconcile with 2009 Update or Monitoring MD performance 2009 (Update = 4.55% and MMP increase in CPC = 3.67%). FY 2009 Maryland growth estimated to be 3.67%

4 - FY 2010 - current MMP increase is 2.48% but update was 1.77%. FY 2010 growth estimated to be 2.0%

5 - National FY 2009 and FY 2010 growth based on Colorado interim data (adjusted for historical bias)

Colorado Adjustment (per AHA/CO ratio)

	NOR				NPR				Cost			
	AHA	CO	Proportion AHA/CO		AHA	CO	Proportion AHA/CO		AHA	CO	Proportion AHA/CO
2003	6.66%	7.40%	90.00%	2003	6.59%	7.40%	89.05%	2003	6.69%	6.80%	98.38%
2004	5.39%	6.20%	86.94%	2004	5.57%	6.00%	92.83%	2004	5.25%	6.00%	87.50%
2005	5.24%	5.60%	93.57%	2005	5.43%	5.60%	96.96%	2005	5.01%	4.80%	104.38%
2006	5.06%	6.50%	77.85%	2006	4.80%	6.10%	78.69%	2006	5.12%	7.00%	73.14%
2007	5.37%	5.60%	95.89%	2007	5.34%	5.30%	100.75%	2007	4.85%	5.50%	88.18%
2008	3.86%	5.30%	72.83%	2008	3.99%	5.50%	72.55%	2008	4.50%	5.10%	88.24%
2009	3.96%	4.60%		2009	3.98%	4.50%		2009	4.05%	4.50%	
2010	2.93%	3.40%		2010	2.74%	3.10%		2010	1.80%	2.00%	
			86.18%				88.47%				89.97%

6 - Estimated MD current position (FY 2010) to be approximately at the National average on Cost/EIPA

7 - Looked at difference between NPR and MB (MB residual)

Market Basket vs. NPR Residual

		NPR	MB	Difference	Proportion
	2006	4.80%	3.90%	0.90%	123.11%
	2007	5.34%	3.38%	1.96%	158.03%
	2008	3.99%	3.59%	0.40%	111.24%
Estimate	2009	3.98%	3.23%	0.75%	123.26%
Estimate	2010	2.74%	1.91%	0.83%	143.60%
	3 year difference 06-08			1.09%	130.79%
	5 year difference			0.97%	131.85%

8 - Assumed US NPR annual increases based on projected MB 2011-2012 and future years (based on 3 year NPR/MB proportion)

		MB	Estimated NPR	Est US NPR per EIPA
Current	2011	2.30%	3.03%	$11,265
Current	2012	2.90%	3.82%	$11,696
Est	2013	3.00%	3.96%	$12,158
Est	2014	3.00%	3.96%	$12,639
Est	2015	3.00%	3.96%	$13,139

Exhibit I (continued)

Generated Maryland Update magnitudes necessary to achieve proposed target over 5 years vis-a-vis the Nation

Net Operating Revenue Per EIPA

	US NOR/EIPA	Growth	MD NOR/EIPA	Growth	Position Above/Below
2000	$7,116		$6,917		-2.80%
2001	$7,486	5.20%	$7,291	5.41%	-2.60%
2002	$7,984	6.65%	$7,624	4.57%	-4.51%
2003	$8,516	6.66%	$7,982	4.70%	-6.27%
2004	$8,975	5.39%	$8,563	7.28%	-4.59%
2005	$9,445	5.24%	$9,041	5.58%	-4.28%
2006	$9,923	5.06%	$9,679	7.06%	-2.46%
2007	$10,456	5.37%	$10,353	6.96%	-0.99%
2008	$10,860	3.86%	$10,857	4.87%	-0.03%
2009	$11,291	3.96% (1)	$11,255	3.67% (3)	-0.31%
2010	$11,621	2.93% (2)	$11,481	2.00% (3)	-1.21%
2011	$11,974	3.04%	$11,700	1.91%	-2.29%
2012	$12,433	3.83%	$11,982	2.41%	-3.63%
2013	$12,926	3.96%	$12,281	2.49%	-4.99%
2014	$13,438	3.96%	$12,587	2.49%	-6.33%
2015	$13,970	3.96%	$12,901	2.49%	-7.65%

Net Patient Revenue Per EIPA

MB		US NPR/EIPA	Growth	MD NPR/EIPA	Growth	Position Above/Below
	2000	$6,689		$6,620		-1.03%
	2001	$7,035	5.17%	$7,037	6.30%	0.03%
	2002	$7,514	6.81%	$7,350	4.45%	-2.18%
	2003	$8,009	6.59%	$7,698	4.73%	-3.88%
	2004	$8,455	5.57%	$8,259	7.29%	-2.32%
	2005	$8,914	5.43%	$8,684	5.15%	-2.58%
	2006	$9,342	4.80%	$9,276	6.82%	-0.71%
	2007	$9,841	5.34%	$9,893	6.65%	0.53%
	2008	$10,234	3.99%	$10,379	4.91%	1.42%
	2009	$10,641	3.98% (1)	$10,760	3.67% (3)	1.11%
	2010	$10,933	2.74% (2)	$10,975	2.00% (3)	0.38%
2.30%	2011	$11,265	3.03% (4)	$11,184	**1.91%** (5)	-0.72%
2.90%	2012	$11,696	3.82% (4)	$11,453	2.40%	-2.07%
3.00%	2013	$12,158	3.96% (4)	$11,738	2.49%	-3.46%
3.00%	2014	$12,639	3.96% (4)	$12,030	2.49%	-4.82%
3.00%	2015	$13,139	3.96% (4)	$12,329	2.49%	-6.17%

Cost per EIPA

	US NPR/EIPA	Growth	MD NPR/EIPA	Growth	Position Above/Below
2000	$6,996		$6,856		-2.00%
2001	$7,314	4.55%	$7,188	4.84%	-1.72%
2002	$7,717	5.51%	$7,496	4.28%	-2.86%
2003	$8,233	6.69%	$7,824	4.38%	-4.97%
2004	$8,665	5.25%	$8,339	6.58%	-3.76%
2005	$9,099	5.01%	$8,767	5.13%	-3.65%
2006	$9,565	5.12%	$9,381	7.00%	-1.92%
2007	$10,029	4.85%	$10,028	6.90%	-0.01%
2008	$10,480	4.50%	$10,486	4.57%	0.06%
2009	$10,904	4.05% (1)	$10,871	3.67% (3)	-0.31%
2010	$11,101	1.80% (2)	$11,088	2.00% (3)	-0.11%
2011	$11,415	2.83%	$11,290	1.82%	-1.09%
2012	$11,823	3.57%	$11,549	2.30%	-2.31%
2013	$12,260	3.70%	$11,823	2.37%	-3.56%
2014	$12,713	3.70%	$12,104	2.37%	-4.79%
2015	$13,182	3.70%	$12,392	2.37%	**-6.00%** (5)

Notes:

(1) Adjusted Colorado (adjusted by proportion of AHA to CO rates of growth historically)

(2) Adjusted Colorado 6 months 2010

(3) Estimated FY 2009 and FY 2010 based on Monitoring MD Performance

(4) Projected US based on NPR as proportion of MB (historical)

(5) Targeting -6.0% below US over five years on Cost - this would require an update of around 1.91% in FY 2010 in order to initiate a trajectory sufficient for the system to reach its goal by FY 2015

Trends in Hospital Input Cost Inflation: The economic slowdown, however, has also had the effect of curtailing the growth in factor costs (the cost of inputs to the production process). Wage growth nationally is flat, with many sectors starting to cut wages (in addition to layoffs and furloughs of employees). Flat or declining wages continue to create slack in the labor market, including the health care sector, which will help alleviate previous shortages of nurses and allied health professionals.

The current estimate (released in April 2010) for increases in hospital input costs (increases in the inputs to the hospital production process) in the coming fiscal year FY 2011 is 2.29%. The hospital input cost inflation estimate consists of both wage and non-wage components. Hospital wages, (accounting for 60% of hospital costs) were projected to increase at 2.40%, while non wage and non-capital items (accounting for 40% of hospital operating costs) were forecasted to grow at 0.94%. These lower than normal trends in the inflation rate of hospital input costs have facilitated hospitals in maintaining relatively steady operating margins in FY 2010. **Table 8** summarizes the estimated increases in hospital input costs by category.

Table 8

Global Insights Market Basket Components (hospital input cost inflation FY 2011)

Global Insights
Market Basket Components
(hospital input cost inflation FY 2011)

Category	% Increase	Weight	
Compensation	2.4%	59.5%	
Utilities	-0.8%	2.1%	-0.02%
Professional Liability Insurance	-0.4%	1.4%	-0.01%
All Other Costs	2.6%	37.0%	0.96%
Non-Capital Total	2.4%		0.94%
Capital	1.1%		
Weighted Cost inflation	2.29%		

Medicare Waiver Situation

Deterioration in recent years: In recent years, the HSCRC has been concerned about unexpected deterioration in the rate system's performance on the Medicare Waiver Test. The deterioration in the test performance has continued through the quarter ending December 2008 (the last official waiver test available), when the relative test was 6.72% (if the relative test drops to 0%, the State will be determined to have failed the test). The State must pass this financial test in order to retain its ability to have Medicare participate in the All-Payer system. Medicare's participation results in the equitable sharing of the costs of Uncompensated Care. Overall, the Medicare Waiver results in over $1 billion per year in enhanced federal reimbursements to Maryland hospitals. In the period FY 2001 – FY 2007, the relative test was in the 12-18% range.

Likely Technical Adjustments to the Waiver Test: It now appears that some of this unexpected erosion in the Waiver Test performance was due to the use of inaccurate data in the calculation of U.S. Medicare payments per case. These technical changes relate to the likely inclusion of two categories of "zero payment" cases (Medicare as Secondary Payer (MSP) and Medicare Advantage/HMO (MA) cases) to the US Medicare data used to calculate the US Medicare Payment per case. This US Medicare Payment per case figure is used in a comparison with Maryland Medicare Payment per case data for purposes of calculating the waiver test.

In recent months HSCRC staff has been meeting with the CMS actuary regarding these likely inaccuracies and the actuary has agreed to two technical changes that should result in an improvement in our relative cushion by 1.7% associated with the removal of the MSP cases and an estimated 3.0% associated with Medicare MA cases.

Should the Medicare Actuary make these adjustments, this should result in an improvement of our waiver position by nearly 5.0% for the period ending September 2009 (relative to what would have been the case had these adjustments not been made).

Further Short-Term Improvement in Waiver due to US Coding and Payment Improvements: Another short-term favorable development for the Maryland's Medicare waiver performance is the projected increases in Medicare Payments to non-Maryland hospitals related to Medicare's conversion to a severity-adjusted DRG grouper and associated case mix coding and documentation improvements for Federal Fiscal Years (FFY) 2008, 2009 and 2010. While this phenomenon will result in a short-term increase in Medicare payments nationally, CMS is implementing current and future "offsets" (reductions to US hospital rate updates) to recoup both permanent and one-time amounts associated with these coding and documentation improvements. It is thus anticipated that Maryland's Medicare waiver cushion will continue to improve from the projected/adjusted levels through FY 2010. Beginning in FFY 2011 however, Medicare is proposing very large offsets to their payment updates to adjust for excessive payments related to coding and documentation improvements.

Revised US Medicare Payments and Waiver Cushion: Table 9 below shows the staff's estimate of the CMS's actuary's "forecast" of FY 2009 and FY 2010 data. **Table 10** then shows the Maryland waiver cushion assuming the CMS actuary makes adjustments for the MSP and MA "zero-pay" cases (the Actuary indicated he believe these adjustments and incorporated in the June 2009 Medicare waiver letter to be sent to the HSCRC sometime in August 2010). Note also, **Table 10** shows the likely impact of a reduction in Medicare one-day length of stay cases of 1.0% relative to historical levels (i.e., Maryland has traditionally had over 17% of its Medicare cases as one day stay cases while the US average for Medicare has been closer to 13%; this adjustment assumes that Maryland will improve its performance on one day stay Medicare cases from 17% to 16% in FY 2010). The result of these actuary adjustments and the staff's anticipated impact on the waiver cushion for reductions in the number of Maryland Medicare one-day stay cases (also factoring in Maryland's slower overall payment growth due to the imposition of a 1.77% update factor in FY10), will be to push the waiver cushion to approximately 13.43% by June 2010.[3]

Table 9

"Forecasted" FY 2009 and FY 2010 Waiver Cushions based on CMS Actuary Estimates of US Medicare Payment Growth and Associated Coding/Documentation Offsets Nationally

A	B	C	D	E	F	G	H
	US Medicare Pmt/Case		MD Medicare Pmt/Case				
1981 base pmt/case	$2,293	US	$2,972	MD	Unadjusted		
	Annualized	Growth	Forecast	Growth	Cushion		
FFY 08 Qtr 4 Dec	**$9,480**	**313.42%**	**$11,501**	**287.02%**	**6.82% Actual**		
Qtr 1Mar CY 08	**$9,547**	**316.34%**	**$11,604**	**290.49%**	**6.62% Actual**		
Qtr 2June	**$9,610**	**319.09%**	**$11,688**	**293.32%**	**6.55% Actual**		
Qtr 3 Sept	**$9,671**	**321.75%**	**$11,849**	**298.72%**	**5.77% Actual**		
FFY 09 Qtr 4 Dec	**$9,808**	**327.72%**	**$11,910**	**300.78%**	**6.72% Actual**		
Qtr 1 Mar CY 09	$9,893	331.43%	$11,974	302.95%	7.07% Projected		<----- Waiver improves
Qtr 2 June	$10,004	336.27%	$12,052	305.56%	7.57% Projected		<----- due to US coding
Qtr 3 Sept	$10,114	341.06%	$12,105	307.36%	8.27% Projected		<----- impact and starting
FFY 10 Qtr 4 Dec	$10,190	344.38%	$12,159	309.15%	8.61% Projected		<----- in Qtr 3 2009 due
Qtr 1 Mar CY 10	$10,267	347.74%	$12,212	310.95%	8.95% Projected		<----- to lower Maryland
Qtr 2 June	$10,344	351.09%	$12,265	312.74%	9.29% Projected		<----- update through FY 10
Qtr 3 Sept	$10,420	354.41%					

[3] Note: this forecast was later amended to reflect only a half year impact of reduced one day stay cases. The staff's most recent estimated waiver cushion for year ending FY 2010 is 13.88%.

Table 10

Adjusted Waiver Cushion based on Expected Adjustments for MSP and MA "Zero-pay" Cases

A		B	C	D	E	F	G
		Unadjusted Cushion		Estimated Annualized MSP Adj	Estimated Annualized MA AdJ	Estimated 1 day LOS Adjustment (1)	**Revised Cushion**
FFY 08	Qtr 4 Dec	**6.82% Actual**					
	Qtr 1Mar 2008	**6.62% Actual**					
	Qtr 2June	**6.55% Actual**					
	Qtr 3 Sept	**5.77% Actual**		1.60%	1.79%		**9.16%**
FFY 09	Qtr 4 Dec 2008	**6.72% Actual**					
	Qtr 1 Mar 2009	7.07% Projected					
	Qtr 2 June	7.57% Projected					
	Qtr 3 Sept	8.27% Projected					
FFY 10	Qtr 4 Dec 2009	8.61% Projected		1.70%	3.00%	-0.56%	**12.75%**
	Qtr 1 Mar 2010	8.95% Projected		1.70%	3.00%	-0.56%	**13.09%**
	Qtr 2 June	9.29% Projected		1.70%	3.00%	-0.56%	**13.43%**
	Qtr 3 Sept						

(1) In FY 2010 it appears that hospitals are systematically reducing Medicare 1 day stay cases. A reduction from 17% to 16% 1 day LOS case a proportion of all Medicare cases would result in a 0.56% erosion in the Medicare waiver.

Potential Medicare Payment Updates - FFY 2011: In April, 2010, CMS released its proposal for the FFY 2011 update for US hospital (effective October 1, 2010). **Table 11** presents this proposed rule which currently reflects a 2.9% reduction to this update related to the above-mentioned case mix/coding and documentation issues. The 2.9% is half of the required one-time reductions associated with coding/ documentation improvements. This proposed rule then also anticipates a second 2.9% offset would occur in FFY 2012.

Separately, Medpac recently approved a recommendation to reduce this 2.9% to a magnitude not to exceed 2.0% for three years FY 2011, 2012 and 2013. Given Congress's tendency to reduce offsets to Medicare updates from what is proposed to the issuance of the final update rule in August, staff anticipates ultimate adoption of the Medpac recommended offsets (shown here as -1.93% which is one-third of the required total 5.8% offset).

Table 11

Medicare Proposed Rule for the FFY 2011 Update to US Hospital Payment Levels

	April 10 CMS Proposed Rule	Medpac Alternative
Market Basket	2.29%	2.29%
MB reduction	-0.25%	-0.25%
Subtotal	2.04%	2.04%
Projected CM	1.00%	1.00%
Subtotal	3.04%	3.04%
Outlier pmt increase	0.40%	0.40%
Subtotal	3.44%	3.44%
Offset for coding	-2.90% (1)	-1.93% (2)
Total pmt increas	**0.54%**	**1.51%**

(1) Proposed rule - April 2010 recommends a 2.90% offset for Case Mix coding/documentation growth of 5.8% (during 2008, 2009 and 201

(2) Medpac recommended to Congress (March 2010 report) to apply Case Mix offset over three years (FFY 2011, 2012, and 2013)

Potential Future Year Updates FFY 2011-2019: The agreement of the CMS actuary to adjust our payment comparison for MSP and MA "zero-pay cases" is certainly a highly favorable development. However, given

large current and projected federal budget deficits and the passage of national health reform, Medicare updates in future years will likely be far less than what has historical magnitudes. **Table 12** is staff's most recent attempt to account for all future and currently planned adjustments to hospital updates and payments for the period FFY 2011-2019 (including staff's best guess for CMS's final update for FFY 2011). Given these likely reduced update magnitudes, it is expected that the Maryland will begin to face significant challenges in avoiding precipitous erosion in the waiver cushion over this 9 year period.

Table 12

Projected Adjustments and Payment Changes per Federal Health Reform Law

Medicare Update Forecast

		A	B	C	D	E	F	G	H	I	J
		2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
	Medicare Update										
(1)	MB		2.30%	2.90%	3.00%	3.00%	3.00%	3.00%	3.00%	3.00%	3.00%
(2)	Outlier Pmts		0.40%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
(3)	DSH		0.00%	0.00%	0.00%	0.00%	-0.47%	-0.47%	-0.47%	-0.47%	0.00%
(4)	Reform		-0.25%	-0.25%	-0.10%	-0.10%	-0.30%	-0.20%	-0.20%	-0.75%	-0.75%
(5)	Productivity		0.00%	0.00%	-1.30%	-1.30%	-1.30%	-1.30%	-1.30%	-1.30%	-1.30%
(6)	Medicare Commission		0.00%	0.00%	0.00%	0.00%	-0.50%	-0.50%	-0.25%	-0.25%	-0.50%
(7)	Coding Retro		-1.93%	0.00%	0.00%	1.93%	0.00%	0.00%	0.00%	0.00%	0.00%
(8)	Coding Prospective		0.00%	-1.50%	-1.00%	-3.00%	0.00%	0.00%	0.00%	0.00%	0.00%
(9)	Case mix		1.00%	0.50%	0.50%	0.50%	0.50%	0.50%	0.50%	0.50%	0.50%
	Projected Updates		**1.52%**	**1.65%**	**1.10%**	**1.03%**	**0.93%**	**1.03%**	**1.28%**	**0.73%**	**0.95%**

Notes:
(1) GII Market Baske (CMS proportions): Per GII book for 2011 and 2012. MB assumed to be 3.0% FY 2013-2019
(2) Additional outlier payment FY 2011 per proposed CMS update regulation
(3) DSH reduction assumed to be 25% of set aside amount over 4 years
(4) Reform offset to MB - per legislation
(5) Reform productivty offset per legislation
(6) Medicare Commission further payment reductions - assumed per reform legislation
(7) Proposed 1-time (retro offset) related to 08, 09 and 10 coding creep - per Medpac recommendation -1.93% for 3 years then assumed reversed in Fy 2014
(8) Authorized 3.9% prospective (permanent) coding offset associated with upcoding in 08 and 09 - start offset in 2012 and continue through 2014 plus -1.0% additional prospective offset for 10 and 11 taken in 2014 (total of minimum -5.34% offset: -3.9% plus -1.0% for 10 and 11 plus interest over 2 years)
(9) Expected Case mix in 2011 = 1.0% per proposed rule; assume reverts to "normal" Medicare case mix change of 0.5% per year

Significant State Budgetary Shortfalls:

General Background: As discussed above, the Board of Public Works recommended additional Medicaid payment cuts in excess of $35 million in FY 2010. In the past, Medicaid payment savings have been achieved through the implementation of Medicaid Day Limits (limitations on payments to hospitals for Medicaid patients above some pre-determined threshold). An additional $10 million of Medicaid payment cuts (associated with the failure of last year's False Claims Act) were included in the Governor's supplemental budget. The Commission believes this approach is both a highly inefficient and inequitable method of achieving such savings. Because Medicaid is funded by both State and federal funds, a payment cut of over $117 million would be required to generate Medicaid General Fund savings of $45 million. These very high payment reductions would then have to be built into hospital UC provisions, which results in cost-shifts to all other payers. To avoid the loss of federal funds and in order to more equitably fund the required budget cuts, the HSCRC implemented a system of direct assessments and hospital remittances to achieve the required $45 million of savings.[4]

The State of Maryland continues to face significant budgetary shortfalls. In response to the worsening budget situation, the Governor's budget allowance for FY 2011 assumes $123 million savings in Medicaid expenditures. Under a "payment cut" approach, a Medicaid payment reduction of $320 million would be

[4] The sharing of the FY 2010 cuts was later amended by the Commission to achieve a 50/50% sharing of the total $45 million in BPW and State Budget bill cuts over the course of 2 years FY 2010 and FY 2011.

required to generate the needed savings. While $123 million equates to approximately 5% of Medicaid hospital payments, $320 million is over 14% of Medicaid hospital payments. The HSCRC could not accommodate payment cuts of this magnitude (which would result in massive revenue reductions to hospitals and/or large increases in hospital UC and UC provisions and loss of federal funds). Thus, the new challenge facing the Commission in attempting to reach a consensus decision on an appropriate Update to hospital rates related to how the rate system should best achieve the required targeted budget savings for FY 2011.

At the Special session held by the HSCRC on April 6, 2010, the Commission voted unanimously to share any or all of the $123 million in required Medicaid savings for FY 2010 30% directly from hospital operating budgets and 70% from an assessment on hospital rates. This decision reflects a departure from the Commission's standing policy to share such burdens 50/50% across hospitals and payers.

Medicaid and Department Budget and Management Determination of Required Savings: The determination of the $123 million required savings related to Medicaid hospital payments was predicated on an assumed all-inclusive and blended inpatient and outpatient HSCRC hospital rate update of 2.82% for FY 2011. If the Commission adopts an Update that is below this assumed 2.82% level, additional savings (versus budgeted levels) will accrue to the Medicaid program and the $123 million assessment/remittance burden can be reduced. To achieve this level of update, the HSCRC would have to approve a base update of 2.05% to generate "all-inclusive" payment increases to Medicaid to match their budgeted increase of 2.82%. In addition, to the base update, hospital markups will be increasing 0.44% due to increases in uncompensated care provisions. The addition of $29 million in restored case mix for early adopters of observation units will increase rates to Medicaid (and all-payers) by 0.21%. Additional, Medicaid payment per case historically grows about 6% faster than the all payer rate. These adjustments account for the difference between the budged 2.82% and the estimated 2.05% (budget neutral) update for Medicaid.

Discussions Regarding Additional Ways to Generate Medicaid Savings

Beyond the debate and deliberations over the FY 2011 Update Factor, a second topic of discussion of Payment Work Group members related to the identification of other ways in which the HSCRC might institute policies that would have the potential for generating additional Medicaid savings, and thereby go to reduce the $123 million in Medicaid cuts to be handled by means of the assessment/remittance mechanism approved by the Commission at its April 6th Special Session. Other initiatives with the potential to generate Medicaid savings and reduce the $123 million Medicaid burden included the following:

1) Lower Update than Budgeted for FY 2011

As discussed in the original draft payment recommendation, if the Update Factor for FY 2011 turns out to be lower than the Update budgeted by the Department of Budget and Management (DBM) (in establishing its FY 2011 budget and determining the need for the additional Medicaid cut, DBM projected a blended inpatient and outpatient update factor – net of changes in markup of 2.82%) this will result in an offset to the Medicaid cuts for FY 2011. Any rate update below this level would generate additional savings that would go to offset a portion of the required Medicaid cut (an offset of the $123 million of about $1 million for every 0.1% the actual update is below the 2.82% combined update less any change in markup for FY 2011). At this stage staff estimates that the markup to rates (related primarily to increases in uncompensated care provisions for FY2011) will approximate 0.44%. An additional $29 million (or 0.21%) revenue is also scheduled to flow into FY 2011 rates (also affecting Medicaid) as a result of the policy to restore lost case mix for hospitals who were early adopters of outpatient observation units. Additionally, Medicaid payments per case historically grow at a 6% faster pace than the all payer rate. This means that the update for FY 2011 must be 2.05% or less to generate additional offsets to the $123 million in Medicaid cuts. An update in excess of 2.05% for FY 2011 will require that amounts in addition to the $123 million budgeted cuts will be required.

2) Examination of Chronic Hospitals' Rate Structures

Payer representatives and representatives of Maryland Medicaid and the Department of Budget and Management have raised concerns regarding the relatively high rate structure of Maryland's five Chronic Care hospitals/units. These hospitals include Levindale Hospital (a member of Lifebridge Health), University Specialty Hospital (a member of the University of Maryland Medical System), Gladys Spellman (a member of the Dimensions Health System), Kernan Hospital and the Mason Lord Center (offering chronic care services at Johns Hopkins Bayview Medical Center).

These representatives believe that the rate structures of these facilities are high relative to alternative providers (Skilled Nursing Facilities) and that a proportion of the care provided by these Chronic hospitals/units (particularly for certain types of patients on ventilators could be adequately delivered at these lower cost settings. It was recommended that the HSCRC undertake a review of these facilities' rates relative to the pricing structure of comparable services at Maryland Skilled Nursing Facilities.

In response, HSCRC staff has undertaken a review of the Chronic hospital charges and cases based on an analysis of the case mix data submitted to the Commission. The HSCRC will report back to the Commission on the results of this analysis and develop recommendations for possible rate action in the coming months.

3) Reductions in State Payments for Maryland Medicaid Patients Receiving Care at Washington DC Hospitals (particularly Children's Hospital of DC)

One payer representative also commented on the relatively high rate structure of Washington DC hospitals, particularly Children's Hospital of DC. It was theorized that Medicaid payments to DC Children's were far in excess of payments for comparable services at the State's two premier academic centers. If this was determined to be the case, it could provide rationale for Maryland Medicaid to lower the payment formula used to reimburse care for DC Children's. Staff and the Department of Health are performing an analysis of Maryland Medicaid payments to DC Children's (using the Johns Hopkins Children's Center as a basis of comparison) to determine if Medicaid payments to DC Children's are excessive and should be reduced. Staff continues to pursue this option and may recommend that the Secretary of Health consider a change to the current reimbursement for formula applied to Children's Hospital as a means of saving the Maryland Medicaid program additional funds and thereby reducing the existing burden for funding Medicaid shortfalls now being shouldered by Maryland facilities and Maryland patients and payers.

4) Pooling of Graduate Medical Education Costs

In FY 2009, in an effort to generate savings to the Maryland Medicaid program, the HSCRC approved full pooling of hospital Uncompensated Care (UC). This proposal resulted in a more equitable distribution of the funding of hospital UC and resulted in an approximate $9 million savings to the Maryland Medicaid program (because Medicaid patients received care at hospitals with higher levels of UC and thus higher overall hospital rates, the Medicaid's share of UC funding was disproportionately higher than that of other payers). Full pooling of hospital UC reduced Medicaid's relative burden and allowed for a more equitable sharing of this social cost. This same logic would apply to the funding of Graduate Medical Education (GME) in the system (that is Medicaid patients are more concentrated at teaching hospitals in the State and thus bear a disproportionate share of the funding of GME). Full pooling of GME would share this burden more equitably across payers and result in Medicaid savings. Staff is completing an analysis of the impact of full pooling of GME. This option is not available to the Commission for FY 2011 as it would require a statutory change.

5) Increasing the Medicare/Medicaid Differentials

Hospital representatives raised the possibility of increasing the "differential" provided by agreement to Medicare and Medicaid (currently these public payers pay 94% of HSCRC charges per the negotiated agreement between Maryland and the federal government under the Medicare waiver). Increasing the differential from the current 6% to some higher amount would result in savings to both the Medicare and Medicaid programs. However, in order to finance full hospital costs – any rate differential results in a direct cost-shift to all other payers in the system. Any additional cost-shifting to private payers would likely have deleterious effects on the affordability of insurance for the citizens of Maryland. Also, a change in the Medicare/Medicaid differential would require approval by the federal government. Staff would strongly oppose any attempt to renegotiate the terms of the Medicare waiver and institutionalize additional cost-shifting to the paying public in Maryland.

Other Topic of Discussion – First Potential "Game Changer"

In addition, the Payment Work Group discussed the need for the development of alternative payment arrangements in Maryland, to strengthen, broaden and align incentives to both improve operating efficiency and quality of care. In that regard, staff has solicited proposals from hospitals for the establishment of Total Patient Revenue (TPR) arrangements with the HSCRC. TPR arrangements establish a global budget cap for a hospital and thus provide very strong incentives for that a facility to control volume and otherwise direct patients to lower cost services and providers. Two hospitals in Maryland (Garrett County and McCready Hospital) are under the TPR rate structure, however as many as 5 hospitals have operated successfully under the TPR. Staff is currently in negotiation with four other hospitals/health systems in an attempt to bring these facilities under the TPR.

Results of these Deliberations

Staff determined that of the identified methods, only items 1, 2, and 3 could potentially be implemented in FY 2011. As discussed, item 1 would require approval of a base Update of less than 2.05% for FY 2011 and would generate approximately $900,000 of Medicaid savings for each 0.1% reduction from the 2.05% level. Item 2 will require a review by HSCRC staff and may involve subsequent staff recommended Commission action. Item 3 requires that staff review the existing payment agreement (in Medicaid regulation) between the Maryland Department of Health and Washington DC hospitals for Maryland Medicaid patients receiving treatment in the District of Columbia.

After performing this review, the HSCRC staff concluded that the Maryland Medicaid payment arrangement with Washington DC hospitals appears reasonable with one exception. Staff concluded that the current payment arrangement between the Maryland Medicaid program and Children's Hospital of Washington DC is excessive due to the inclusion of a negotiated extra factor in the hospital's payment formula. The Department's regulation currently authorizes an extra payment multiple for Children's Hospital of 2.5 x Children's reported Uncompensated Care. All other Washington DC hospitals are paid at a multiple of 1.0 x reported Uncompensated Care. This extra payment multiple will result in approximately $4 - 5 million in excessive and unnecessary payments by Maryland Medicaid to Children's Hospital in FY 2011. Elimination of this multiple would reduce the assessments currently imposed on Maryland hospitals and payers.

Staff suggested that the Payment Work Group make a joint recommendation to Medicaid to change their reimbursement formula for Children's Hospital of DC to adjust this factor to 1.0 (the same as exists for all other District providers). Payer members representing CareFirst, Kaiser, and United Healthcare agreed with this recommendation. The Maryland Hospital Association did not support the staff recommendation. Staff contacted Children's representatives and indicated they could have time today to respond to these recommendations. These representatives, however, declined to participate.

Staff will recommend that the Commission send a letter to the Maryland Secretary of Health recommending this change to Maryland Medicaid reimbursement methodologies. The reductions of these unnecessary payments will thus go to reduce the $123 million assessment to be imposed on Maryland hospitals and payers in FY 2011.

Update Proposals from Hospitals and Payers

Each of the following proposed update options contains the key components illustrated in Table 3 above and described below:

1- **Market Basket (MB):** Estimate of 2.29%. The Market Basket is a fixed-weight index that measures price changes in the underlying factor inputs used in the hospital production process, as per HSCRC policy determined by Global Insight's 1st quarter book 2010 for the period July 1, 2010 – June 30, 2011 (and applicable time-period for a 3 year rate proposal). [5]

2- **Market Basket forecasting error**: Estimate of 0.38%. This is an adjustment for historical trends in forecasting error by Global Insight. [6] The Commission has periodically included a factor to account for inflation forecasting errors over time. Forecasting errors are usually related to the inability to predict untoward catastrophic events such as the Iraqi war and hurricane Katrina. CMS does not include a forecast error in their hospital update.

3- **HSCRC Policy Adjustment**: (Update Options vary in the magnitude proposed). In past years, the HSCRC Update has contained either a reduction to trend as a means of constraining revenue growth and hospital cost growth (productivity factor), or additions to trend to help improve the financial condition of the hospital industry.

4- **Rate "Slippage"**: Quantified to be 0.3% for FY 2011. This component is an estimate of deviations from approved revenue growth as a result of other features of the rate setting system – such as rate increases granted individual hospitals, the impact of "Spend-down" agreements, or other factors.

5- **Case mix Allowance:** Represented as 0.75% for inpatient and 1.35% for outpatient. An allowance or limit on annual increases in measured additional resource use due to increase in measured patient severity of illness. Case mix allowances can apply to both inpatient and outpatient services.

6- **Volume Adjustment**: Currently estimated to be 0.23% for FY 2011. This adjustment represents Commission policy regarding recognition of fixed and variable components of hospital cost. Current Commission policy is to recognize hospital costs as 85% variable. **Table 13** shows the staff's current estimate of the volume adjustment for FY 2011 (based on 10 months of data for FY 2010 vs. FY 2009).

[5] The market basket forecasts are developed on a quarterly basis by Global Insight Inc. (GI) under contract with the Center for Medicare and Medicaid Services (CMS). Updates to the market basket are available on a quarterly basis (lagged one quarter) with historical data also being updated at this time. Global Insight Inc. is a respected economic forecasting firm with the detailed macroeconomic and industry knowledge and expertise needed to forecast the price series used in the market basket. The forecasts are available for a 10-year period.

[6] Because many of the current payment systems adjust payments on a prospective basis, the market basket increases used in those updates are a forecast of what those increases will be. The actual market basket increase for a given period can be higher or lower than the forecasted increase available at the time a payment update is determined. This phenomenon is commonly known as forecast error. For example, in the spring of 2010, the HSCRC was required to forecast the market basket increase for fiscal year 2011. The actual change in the market basket for FY 2011 may be higher or lower than what we forecasted in the spring of 2010 depending on market conditions.

Table 13

Estimated Volume Adjustment for FY 2011 Update

Calculation of Volume Adjustment

Gross Revenue from FS Schedules	Inpatient	Outpatient	Total
Year to Date 7/1/08 to 4/30/09 (FY 2009)	$7,552,392.5	$4,266,751.2	$11,819,143.8
	63.90%	36.10%	100.00%
Year to Date 7/1/09 to 4/30/20 (FY 2010)	$7,672,819.1	$4,627,181.8	$12,300,000.9
	62.38%	37.62%	100.00%
Calculation of Volume Adjustment:			
Admissions/EIPA's YTD 3/31/10	576,682	347,775	924,457
Admissions/EIPA's YTD 3/31/09	581,859	328,723	910,582
Percent Change	-0.89%	5.80%	1.52%
Fixed Cost Factor	15.00%	15.00%	15.00%
Volume Adjustment (applied equally to I/P and O/P)			-0.23%

Maryland Hospital Association Proposal

The MHA chose to submit a one-year rate proposal, due to "current uncertainty regarding national health care reform discussions, the State's budget situation, as well as expected discussions over the next year on the development of a modernized vision for Maryland's Medicare wavier and future payment system" (the MHA Proposal). Subsequent to their initial submission, the MHA did modify their proposal slightly (changing several components of their proposal which resulted in a reduction to their original proposal of 0.4% to reach a combined inpatient and outpatient update of approximately 3.28%). Staff has slightly modified the original MHA Proposal for purposes of comparability.

Table14

Hospital Revised One-Year Payment Update Proposal

Proposed Update Factor (MHA Proposal)

Rate Year Ending June 30, 2011
One Year Arrangement

	Inpatient	Outpatient	Total
Global Insight's - 1st Qtr Book for RY 6/30/11	2.29%	2.29%	2.29%
Inflation Forecast Error	0.38%	0.38%	0.38%
Subtotal Inflation Allowance	2.67%	2.67%	2.67%
Policy Adjustment (Improvement to US)	-0.48%	-0.48%	-0.48%
Subtotal Update	2.19%	2.19%	2.19%
Slippage For RY 2010	0.03%	0.03%	0.03%
Rate Update Provided	2.22%	2.22%	2.22%
Volume Adjustment (RY 2010 over RY 2009)	-0.23%	-0.23%	-0.23%
CMI Adjustment (Lower of Actual or Limit)	0.75%	1.35%	0.98%
Full Update Provided	**2.74%**	**3.34%**	**2.97%**
Estimated Volume Increase (RY 2011)	-0.89%	4.39%	1.10%
Overall Revenue Increase			4.07%

At the April 26th meeting of the Payment Work Group, the MHA further agreed to take 100% of any additional funding of Medicaid savings shortfalls that might be produced from an Update that exceeds the Medicaid budgeted FY 2011 level of 2.82%. MHA further revised their recommendation at the June 14 meeting of the Payment Work group to change the policy adjustment to from a -0.10% to -0.48%, thus lowering their proposed update by 0.38%. The revised proposal is shown in **Table14** above.

Explanatory Notes to the Tables and MHA Proposal: Staff notes that the MHA Proposal contains an adjustment for "forecasting error" of the Global Insight Market Basket. This forecasting error is based on deviations from actual final inflation over the past three years. Additionally, in their original submission, the MHA showed a combined Policy and Volume adjustment. For purposes of comparability, HSCRC staff has segregated these two components in the table above. Finally, MHA has proposed a 0.75% case mix limitation on inpatient Charge per Case (CPC) with no limitation on outpatient case mix. FY 2011 is expected to be the initial measurement year for the Commission's new Charge per Visit (CPV) methodology (the per-visit bundled payment system covering most hospital clinic, emergency room, and ambulatory surgery visits). Staff expects some case mix increase associated with the implementation of the CPV. Additionally, outpatient services not covered by the CPV are likely to generate increased revenues for the hospital. The MHA originally proposed that no "cap" on CPV case mix growth be applied. However, at the June 14 meeting of the Payment Work Group, both payer and hospital representatives seemed receptive to the use of a 0.75% cap on inpatient case mix and 1.35% cap on outpatient (CPV) case mix. Although MHA has not officially agreed to an outpatient case mix cap, staff is reflecting a 1.35% cap for all update proposals.

MHA's Additional Adjustments: The MHA did not respond to the staff's request for recommended update magnitudes for specialty hospitals (chronic, private psychiatric, and other). Recently however, the MHA did present a revised proposal for scaling related to individual hospital performance on Reasonableness of Charges (ROC) position; Quality-based Reimbursement (QBR) and Maryland Hospital Acquired Conditions (MHACs). MHA believes redistribution of a portion of the annual payment update or "scaling" based on a statewide comparison can be an effective policy tool. Scaling has been used to redistribute revenue among hospitals according to their position on the Reasonableness of Charge (ROC) analysis and the Quality Based Reimbursement (QBR) policy. For the first time, in FY 2011, payment will be scaled based on hospitals' relative rate of potentially preventable complications (PPCs). In all cases, hospitals are ranked relative to all other hospitals in the State and rewarded or penalized based on their position in the ranking.

MHA Scaling Proposal

For FY 2011, Maryland hospitals support scaling a portion of the annual update, provided the scaling is handled in a certain manner.

Amount of Revenue to Scale

In scaling a portion of the annual payment update, it is important that the core update (GI inflation, plus forecast error, plus or minus any policy adjustment) is at least equal to inflation. MHA supports scaling for the quality-based initiatives as a first step, with ROC scaling established such that the combined scaling for all of the three comparison indices - ROC, QBR, and PPCs combined— results in no individual hospital receiving a combined negative scaling greater than 30 percent of the core inflation update. We would accept the quality-based scaling as proposed by the payers at present for 2011 (0.50% set aside for each of QBR and PPCs).

Scaling Design

For the ROC, MHA supports continuous scaling at a level of 10% of the difference between a hospital's position on the ROC and its peer group average. This proposal reflects a substantial change from the earlier proposals for scaling advanced by the MHA.

A simulation of the MHA scaling proposal is included in **Appendix I.**

Other MHA Observations: In developing the hospitals' proposal, the MHA thought it important to differentiate between the approved HSCRC Update for FY 2010 and what Maryland hospitals actually will receive in the way of increased revenue for the year. The Board of Public Works (BPW) required Medicaid hospital payment reductions of over $27 million during the course of FY 2010 (this figure was later reduce to $17 million net for FY 2010 based on later Commission action regarding the sharing of the FY 2010 Medicaid-related cuts). These amounts were realized through a direct remittance by hospitals of these funds to the Department of Health and Mental Hygiene (DHMH) in lieu of actual reductions to Medicaid payment. Additionally, the MHA wished to highlight the prospective adjustment to hospital Uncompensated Care (UC) provisions in FY 2010 related to recent Medicaid eligibility expansions. These adjustments reduced hospital UC provisions by a collective 0.75% for "averted uncompensated care" resulting from the expected increases in individuals becoming insured through the Medicaid program.[7] The MHA believes that these two adjustments to hospital revenues resulted in "near-zero growth in reimbursement rates so far for this year."

Wavier "Trip Wire": The MHA also indicated continued support for a waiver "trip wire" at the 7.0% cushion level on the Medicare Waiver test. That is, if the system should ever be projected to drop below the 7.0% level (as projected by staff per its usual methodology), the Commission should take immediate corrective action to restore the cushion.

While, staff believes the "trip-wire" policy and action plan constitutes an important policy for the Commission to retain, it would point out that in the past the MHA has argued against the Commission rate reductions as the means of restoring the minimum waiver margin and instead advocated an increase in the Medicare and Medicaid differentials (i.e., greater discounts for public payers and a direct cost shift to private payers).

As mentioned previously, staff believes that changes to the Medicare differential are anathema to the All-Payer nature of the Rate Setting System.

Staff would also note that under a MHA-style Update out into future years commensurate to the Update advocated by the MHA for FY 2011, the Rate System would pierce the 7.0% waiver "trip-wire" in 2 years (FY 2013). From that point forward, the HSCRC would need to provide the following rate Updates for the years FY 2014-2019, per the projected Medicare updates based on current law.

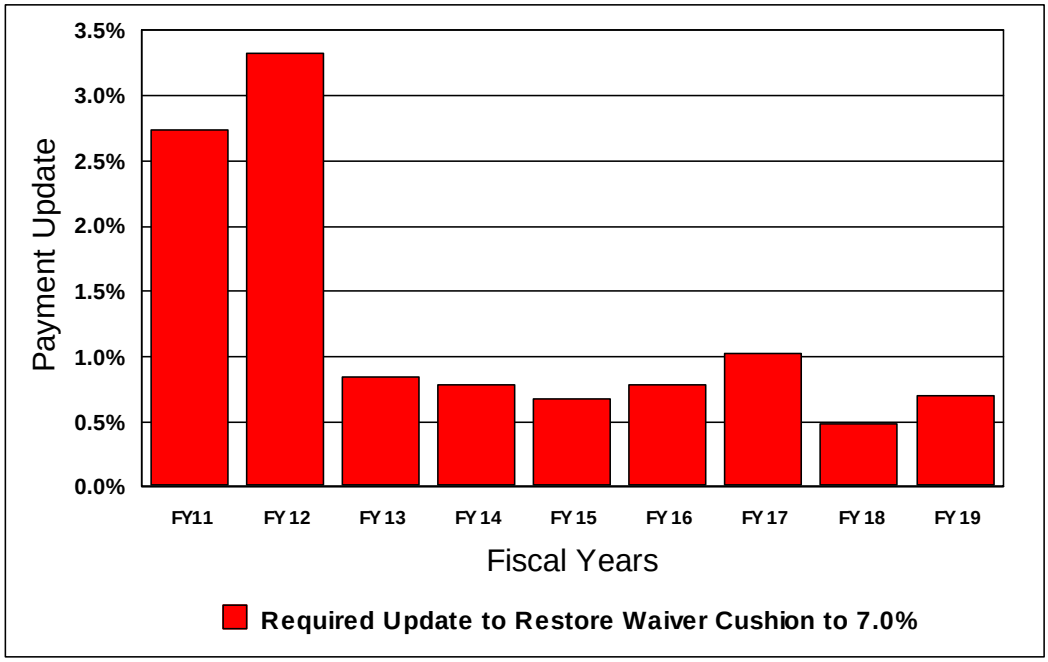
Table15

Rate Updates Required if Waiver "trip-wire" is Pierced

	2011	2012	Trip-Wire Pierced 2013	2014	2015	2016	2017	2018	2019
Projected Updates	**1.52%**	**1.65%**	**1.10%**	**1.03%**	**0.93%**	**1.03%**	**1.28%**	**0.73%**	**0.95%**
MHA Magnitude Update	2.74%	3.33%							
Waiver Cushion per MHA Magnitude Update	11.28%	9.34%	**6.77%**	4.77%	2.03%	1.54%	1.29%	0.00%	-1.07%
Required Update to avoid additional Erosion			1.10%	1.03%	0.93%	1.03%	1.28%	0.73%	0.95%
Update required to Restore Cushion above 7.0%			**0.85%**	**0.78%**	**0.68%**	**0.78%**	**1.03%**	**0.48%**	**0.70%**

[7] The Commission has agreed that these reductions to hospital Uncompensated Care provisions will ultimately be reconciled with data from the Medicaid program and thus these adjustments will not constitute shortfalls in revenue for the hospital system.

Chart 4
Rate Updates Required if Waiver "trip-wire" is Pierced



Payer Representatives' Proposals

Originally, representatives from United Health Care, CareFirst & Kaiser Permanente, Amerigroup, DHMH, and the State Health Employee Benefit Program collectively submitted both a one-year and a three-year proposal (the Payer Proposal). As a result of the passage of national health reform legislation and other events, the payer representatives decided to only submit a one-year rate update proposal. The CareFirst/Kaiser and United Health Care each now have their own one-year proposal. The detailed provisions of the proposal are also discussed in the section that follows.

Rationale for Payers' One-Year Proposals: As noted, both CareFirst/Kaiser and United Health Care decided to submit only a one-year update proposal because of growing uncertainty about the impact of recent federal and State legislation on payment levels and the financial condition of hospitals.

Payer One-Year Proposal: At the March Commission meeting, representatives from United Health Care indicated their willingness to modify their original one-year proposal to be at least equal to last year's approved update of 1.77%. This proposal was later modified following the Commission's decision to change the allocation of the funding burden between hospitals and payers (from 50/50 to 30/70) associated with the $123 million in required Medicaid savings for FY2011. The modified United proposal results in a reduction of the 1.77% update to 1.58% accounting for the additional assessment amounts now being imposed on the payers as a result of the Commission's April 6th decision. Subsequent to this revision, Care/First and Kaiser Permanente also revised their rate update to reflect a 1.58% total update after volume adjustment. The Payer's current proposal is shown in **Table 16.**

Table 16
Proposed Update Factor (Payers)

Rate Year Ending June 30, 2011
One Year Arrangement

	Inpatient	Outpatient	Total
Global Insight's - 1st Qtr Book for RY 6/30/11	2.29%	2.29%	2.29%
Inflation Forecast Error	0.38%	0.38%	0.38%
Subtotal Inflation Allowance	2.67%	2.67%	2.67%
Policy Adjustment (Improvement to US)	-1.87%	-1.87%	-1.87%
Subtotal Update	0.80%	0.80%	0.80%
Slippage For RY 2010	0.03%	0.03%	0.03%
Rate Update Provided	0.83%	0.83%	0.83%
Volume Adjustment (RY 2010 over RY 2009)	-0.23%	-0.23%	-0.23%
CMI Adjustment (Lower of Actual or Limit)	0.75%	1.35%	0.98%
Full Update Provided	**1.35%**	**1.95%**	**1.58%**
Estimated Volume Increase (RY 2011)	-0.89%	4.39%	1.10%
Overall Revenue Increase			2.68%

Scaling for ROC, QBR and MHACs: The Payers collectively voiced belief that the adjustments for quality measures (including the QBR and MHACs), should be revenue neutral, but yet include incentives that will influence future behavior. They also believe more emphasis should be given to Potentially Preventable Admissions, including readmissions (PPAs), which we believe will have a greater quality and financial impact, and propose a pool of 0.5% for the QBR, 0.5% for the MHAC adjustment, and 1.0% for the Potentially Preventable Readmission program in 2011, all increasing by 0.5% a year in 2012 and 2013.[8]

With regard to ROC scaling, the collective Payer proposal is as follows:

1. The level of scaling should be driven by the ROC than by the update factor. Scaling is to relate to whether a hospital's charges are high or low and that has nothing to do with the update factor.

2. Scaling should be revenue neutral.

3. Scaling should aggressively address the "stuck hospital" issue. That is, hospitals with very low rates should be approved for significant positive scaling.[9]

[8] While the HSCRC is currently developing a methodology for linking the performance on potentially preventable re-admissions (PPRs) to payment incentives, this methodology was not contemplated to be associated with the FY2011 payment update. Staff, however, intends to present a recommendation linking PPR performance by hospital to payment incentives in the FY 2012 Update.

[9] Note: the Staff's Recommendations for the ROC/ICC this year is to forestall the implementation of "Spend-downs," agreements (negotiated rate reductions to high charge hospitals over 2-3 years) in lieu of more "aggressive" scaling (that is apply larger than historical magnitudes of scaling revenue – based on relative ROC position). In the absence of aggressive scaling, the staff will institute the HSCRC's long-standing policy of negotiating Spend-downs for high charge hospitals.

4. Hospitals should not be entitled to both scaling and a full rate review.

5. Two hospitals be exempt from scaling (McCready Hospital because it is a TPR hospital that is above the ROC average and Bon Secours, because of financial issues). [10]

6. The Payers propose the scaling be accomplished in two steps: Step one – the hospitals subject to scaling gain or lose 20% of the difference in their ROC position and 0% (peer average). Step two – staff makes a revenue neutral adjustment by increasing or decreasing the adjustment for high-charging hospitals.

7. The Payers recognize that in conjunction with their update proposal, some very high charge hospitals will have their charges reduced in the first year. This, they believe is entirely consistent with the Commission's mission and the payers' conception of appropriately achieving affordable hospital care and the payers' original goal of reaching a position of 6.1% below the US in terms of cost per EIPA.

8. Note that aggressive scaling would replace Spenddowns. In a typical spenddown, a high cost hospital's ROC position is reduced to the statewide average in three years. The Payer proposal moves all hospitals to approximately 50% of their current ROC position in three years (0.8 x 0.8 x 0.8 = 0.512).

A simulation of the Payer scaling proposal is included in **Appendix I.**

Adjustments to Volume Adjustment and Case Mix and Volume: The CareFirst proposal also includes a volume adjustment per Commission policy of 85% in FY 2011and the proposal also describes the method for calculating allowed case mix change and recommends some allowance for higher than 1.0% case mix in the event that hospitals reduce admissions and overall volume in the system. Case mix would be set at 1% each year; however, if reported case mix is less than 1%, the following year's Update will be larger than otherwise. If overall volume falls, as measured by case mix adjusted EIPAs, the hospitals should get an additional 0.25% for case mix, and the proposed targets would be adjusted so that additional dollars would be added to the system. The same would be true for any overall positive adjustment under the variable cost adjustment. The Payers also indicate their concern over the reporting of case mix data and suggest that the HSCRC add money to finance a competitive bid for an independent audit of case mix reporting.

Waiver "Trip-Wire": The Payers collectively proposed a "waiver trip-wire" that is based on the HSCRC staff's forecasted waiver position after agreed upon technical corrections are accomplished. Under this structure, Commission action to reduce rates would occur if the forecasted waiver cushion were projected to be less than 7% at the end of the three-year agreement. Staff would provide a revised waiver forecast through 6/30/13 each quarter after a new waiver letter is received.

Recommended Rate Review of Chronic Care Hospitals: In response to the staff request to propose an Update for specialty hospitals, the Payers expressed reluctance to suggest a precise Update factor in the absence of data on case mix, payer mix, volume change, and profitability of these hospitals. The Payers did, however, indicate concern regarding the level of approved rates at the chronic hospitals. They recommended that the HSCRC undertake a comprehensive review of chronic hospital rates relative to the rates of comparable services at non-chronic hospital providers (particularly for Vent and Rehabilitation patients treated at Skilled Nursing Facilities) and the appropriateness of admissions resulting from transfers between acute and chronic hospitals. Finally, the Payers expressed concern regarding the "weaning" rates of vent patients in both acute and chronic facilities. This also is a recommended topic of review for the HSCRC.

[10] The Payers note that the HSCRC may wish to look at these two facilities separately. Bon Secours is the only non-teaching Baltimore city hospital and may be disadvantaged by being in a group with city teaching facilities. The Payers do not favor a policy that could bankrupt Bon Secours and divert patients to higher charge hospitals that only "appear" lower on the ROC because their teaching adjustment.

Recommendation to Identify and Pursue "Game Changers": The Payers collectively believe that both hospital and overall health care costs are much too high. While the moderation of growth rates may be helpful in stemming this tide, what is needed, according to the Payers, are so-called "Game Changers." Accordingly, the Payers recommend that during the three year rate cycle, a standing group of hospital and payer representatives and HSCRC Staff should be meeting regularly to identify and recommend the implementation of Game Changers, that is, initiatives that will materially reduce the cost of providing quality health care, by changing the way services are delivered by volume, by location, by personnel, by time, by modality, etc. Moreover, the payers are fully committed to sharing any resulting gains with the hospitals. Part of this strategy may well be encouraging hospitals, or health systems, to adopt the Total Patient Revenue (TPR) constraint.

Other Update Options Developed by Staff

During the course of the deliberations over the FY 2011 Rate Update, the Chairman of the HSCRC requested that staff develop other options for update magnitudes to be considered by the Commission. In response to the Chairman's request, staff developed Update proposals as follows: 1) an Update magnitude for FY 2011 that would result in no erosion of the Medicare waiver for FY 2011 (the "No-Erosion" Option); 2) an Update magnitude that would result in no additional assessment on hospitals and payers related to the projected Medicaid budget deficit for FY 2011 (referred to in this document as the "Peg Medicaid" option); and a third Update magnitude that would be necessary to start the Rate Setting system on a trajectory to move from an estimated position of -0.11% below the US to 6.0% below the US hospital industry on the basis of hospital cost per Equivalent Inpatient Admission (EIPA). These additional update options are shown in Tables **17**-**20** below.

Table 17
Proposed Update Factor (No Erosion)

Rate Year Ending June 30, 2011
One Year Arrangement

	Inpatient	Outpatient	Total
Global Insight's - 1st Qtr Book for RY 6/30/11	2.29%	2.29%	2.29%
Inflation Forecast Error	0.38%	0.38%	0.38%
Subtotal Inflation Allowance	2.67%	2.67%	2.67%
Policy Adjustment (Improvement to US)	-2.68%	-2.68%	-2.68%
Subtotal Update	-0.01%	-0.01%	-0.01%
Slippage For RY 2010	0.03%	0.03%	0.03%
Rate Update Provided	0.02%	0.02%	0.02%
Volume Adjustment (RY 2010 over RY 2009)	-0.23%	-0.23%	-0.23%
CMI Adjustment (Lower of Actual or Limit)	0.75%	1.35%	0.98%
Full Update Provided	**0.54%**	**1.14%**	**0.77%**
Estimated Volume Increase (RY 2011)	-0.89%	4.39%	1.10%
Overall Revenue Increase			1.86%

Table 18
Factor (Peg Medicaid)

Rate Year Ending June 30, 2011
One Year Arrangement

	Inpatient	Outpatient	Total
Global Insight's - 1st Qtr Book for RY 6/30/11	2.29%	2.29%	2.29%
Inflation Forecast Error	0.38%	0.38%	0.38%
Subtotal Inflation Allowance	2.67%	2.67%	2.67%
Policy Adjustment (Improvement to US)	-1.40%	-1.40%	-1.40%
Subtotal Update	1.27%	1.27%	1.27%
Slippage For RY 2010	0.03%	0.03%	0.03%
Rate Update Provided	1.30%	1.30%	1.30%
Volume Adjustment (RY 2010 over RY 2009)	-0.23%	-0.23%	-0.23%
CMI Adjustment (Lower of Actual or Limit)	0.75%	1.35%	0.98%
Full Update Provided	**1.82%**	**2.42%**	**2.05%**
Estimated Volume Increase (RY 2011)	-0.89%	4.39%	1.10%
Overall Revenue Increase			3.15%

Staff would note that the MHA disagreed with the conclusion that 2.05% constituted an Update that would hold Medicaid "harmless" from a budgeted revenue standpoint in FY 2011 (the staff calculation is shown below).

MHA has also indicated in its proposal, that should the approved Update be greater than a "revenue neutral" level from the standpoint of budgeted Medicaid expenditures for FY 2011, the hospital industry would absorb 100% of any additional assessment that would be required.

Table 19

Calculation of "Revenue" Neutral Update
Relative to FY 2011 Medicaid Budgeting
and application of the Medicaid Assessment

	FY 2011
DBM (Medicaid) Budgeted HSCRC Update FY 2011	2.82%
Markup Increase in FY 2011	0.44%
	2.39%
Medicaid Historical Growth as a proportion to All-Payer Update	106%
	2.26%
Additional amounts in Rates in FY 2011 due to CMI restoration for Observation Adopters	0.21%
All-Payer Update needed to avoid additional Assessments	**2.05%**

Table 20

Proposed Update Factor (Target -6.0% Cost Position)

Rate Year Ending June 30, 2011
One Year Arrangement

	Inpatient	Outpatient	Total
Global Insight's - 1st Qtr Book for RY 6/30/11	2.29%	2.29%	2.29%
Inflation Forecast Error	0.38%	0.38%	0.38%
Subtotal Inflation Allowance	2.67%	2.67%	2.67%
Policy Adjustment (Improvement to US)	-1.54%	-1.54%	-1.54%
Subtotal Update	1.13%	1.13%	1.13%
Slippage For RY 2010	0.03%	0.03%	0.03%
Rate Update Provided	1.16%	1.16%	1.16%
Volume Adjustment (RY 2010 over RY 2009)	-0.23%	-0.23%	-0.23%
CMI Adjustment (Lower of Actual or Limit)	0.75%	1.35%	0.98%
Full Update Provided	**1.68%**	**2.28%**	**1.91%**
Estimated Volume Increase (RY 2011)	-0.89%	4.39%	1.10%
Overall Revenue Increase			3.01%

Staff Proposed Scaling Adjustment

As mentioned earlier in this recommendation, staff has recommended the application of an aggressive and continuous scaling of the ROC results. Thus staff is also proposing a scaling recommendation that would scale 15% of the difference a given hospital's ROC position (per the recently adopted FY 2010 ROC) and 0% (the peer average). In addition, staff originally recommended no longer scaling relative performance of hospitals on the HSCRC's Quality Based Reimbursement methodology for the following reasons:

- **Narrow focus of the measures**- The QBR process measures focus narrowly on CHF, AMI, Pneumonia and surgical care patient populations, and the upcoming new inpatient measures focus on these same patient populations with exception of the asthma measures which represent small numbers of inpatients. The initial 19 measures used for the QBR constitute only about 15% of the hospital discharges in Maryland and approximately 30% of total Maryland hospital charges, based on fiscal year 2007 data.
- **Several topped off measures that do not distinguish hospital performance**- with use over time, many of the initial 19 process measures show hospitals performing well across the board, so the measures do not distinguish hospital performance from one another.
- **Financial impact on hospitals is minimal**- Relative to the work involved in analyzing the data to determine the QBR scores and reflect the results in the payment update factor, the financial impact is very small for hospitals with a 0.15% spread of revenue difference between the highest and lowest performers.
- **Focus on attainment an improvement further narrows the differences in performance-** The design of the QBR methodology to recognize the better of attainment and improvement further narrows the differences in hospital performance.
- **Monitoring performance on QBR measures for slippage may be the best option-** to ensure that there is not an unintended consequence of hospital performance declining after removing the QBR measures from the quality initiatives implemented by HSCRC, we will continue to monitor hospital performance on these measures. and to consider the impact that moving to an appropriateness model would have on the distribution of scores

After further discussion at the Payment Work Group, the staff 's recommendation on quality-related scaling will be to retain the 0.5% QBR and 0.5% MHAC magnitudes for scaling purposes for FY 2011. Both the ROC and MHAC scaling adjustments would be additive by hospital.

Staff would further recommend that this scaling adjustment be revenue neutral to the system and that no hospital could receive a cumulative negative adjustment greater than the approved base update (Market Basket plus forecast error plus policy adjustment plus slippage). Hospitals should not be entitled to both scaling and a full rate review and three hospitals be exempt from ROC scaling (McCready Hospital because it is a TPR hospital that is above the ROC average and Bon Secours, because of financial issues.

In lieu of an aggressive scaling proposal, per the ROC approved recommendations, staff would pursue spenddown agreements with all high-cost hospitals (those more than 3.0% above their peer group average).

A simulation of the Staff scaling proposal is included in **Appendix I.** A comparison of all three scaling proposals is shown in **Table 30** later in this document.

All Proposed Update Options Compared

Payer and Hospital Proposals

Table 21 summarizes the original hospital and payer proposals for an update to both inpatient and outpatient hospital rates for FY 2011. Staff has also estimated hospital volume growth to be approximately 1.10% in FY 2011 (based on FY 2010 YTD growth of both inpatient and outpatient volumes). The projected increase in hospital volumes is then added to each Update Option to provide an estimate of overall increase in system revenue under each scenario.

Table 21

Detailed Comparison of all Update Proposals (Options 1 -5)

Summary of Update Options	**Option 1** Steady on Waiver Test	**Option 2** Payer Proposal	**Option 3** Update for trajectory to a position of 6.0% below US Cost/EIPA	**Option 4** Peg" Medicaid Budgeted Update	**Option 5** MHA Proposal
Global Insight's - 1st Qtr Book for RY 6/30/11	2.29%	2.29%	2.29%	2.29%	2.29%
Inflation Forecast Error	0.38%	0.38%	0.38%	0.38%	0.38%
Subtotal Inflation Allowance	2.67%	2.67%	2.67%	2.67%	2.67%
Policy Adjustment (Improvement to US)	-2.68%	-1.87%	-1.54%	-1.40%	-0.48%
Subtotal Update	-0.01%	0.80%	1.13%	1.27%	2.19%
Slippage For RY 2010	0.03%	0.03%	0.03%	0.03%	0.03%
Rate Update Provided	0.02%	0.83%	1.16%	1.30%	2.22%
Volume Adjustment (RY 2010 over RY 2009)	-0.23%	-0.23%	-0.23%	-0.23%	-0.23%
CMI Adjustment (Lower of Actual or Limit)	0.98%	0.98%	0.98%	0.98%	0.98%
Full Update Provided	**0.77%**	**1.58%**	**1.91%**	**2.05%**	**2.97%**
Estimated Volume Increase	1.10%	1.10%	1.10%	1.10%	1.10%
Overall Revenue Increase	1.87%	2.68%	3.01%	3.15%	4.07%
Difference between MHA and Payers			1.39%		
			$187.7 million		

Description of Options

Option 1: The intent of Option 1 is to establish an Update that will result in no erosion of the Medicare waiver cushion in FY 2011. This option assumes that the final Medicare Update rule incorporates one-time coding offsets per the Medpac recommendation to Congress of March 2010 (a 1.93% offset instead of the 2.9% offset in the CMS proposed rule). This option would result in an update that is less than the 2.82% DBM budgeted Update and thus would reduce the amount of Medicaid shortfalls that must be funded through the system of assessments and remittances (by over $17 million - bringing the $123 million down to $106 million).

Option 3: This Option was developed in the context of the Commission modifying the current HSCRC system efficiency target to be reaching a level of 6.0% below the US on hospital cost per EIPA by the year 2015. The current efficiency target is to be 3.0%-6.0% below the US on cost per EIPA but there is no specified time frame for reaching that goal. As indicated previously the rationale used in recommending this target is as follows:

In reaching this policy target of 6.0% below the US, the staff used the following rationale:

1) the HSCRC's current policy is a range – to be 3-6% below the US on Cost per EIPA (although the system is currently only 0.21% below);

2) the Maryland system has historically been as low as 11-12% below the US on this measure (in the 1992-1993 period), so much lower levels of relative cost efficiency are achievable;

3) Medpac has demonstrated that the most efficient hospitals in the US (those facing broad financial constraint by both public and private payers) are currently about 9.0% below the US average cost per EIPA level;

4) Gradual improvement of approximately 1.25% per year relative to the US will help the system minimize an erosion of the Medicare waiver;

5) Improvement on an efficiency basis will result in improved relative affordability of hospital care in Maryland relative to the US, which will be vitally important in an era of massive health insurance expansion (other states such as Massachusetts, that have moved aggressively to expand access to health insurance without taking steps to improve system affordability, are in severe danger of not being able to sustain their access expansions);

6) Adopting a policy to improve vs. the nation in cost performance will require rate pressure. This rate pressure will provide stronger incentives for hospitals to reduce large and rapidly growing unregulated operating losses;

7) If the system underperforms and does not achieve the necessary year-to-year reductions – then the system will at least be moving in an appropriate direction, and the result will be consistent with current Commission policy (to be 3 to 6% below the US on Cost per EIPA).

Payer representatives have pointed out that the Rate System is unlikely to reach a level of 6.0% by FY 2015, as projected by staff, if Maryland continues to improve on its proportion of One Day Stay (ODS) cases.

Option 4: This level of Update is one that approximates the HSCRC Update that the Medicaid and Department of Budget and Management (DBM) used as the basis of their budget for FY 2011. Staff calculated that an Update of 2.05% will meet that DBM budgeted level. Any update in excess of this level will trigger additional system assessments.

Impact Analysis of Various Options

To assess the potential impact of each Update Option, staff prepared an analysis that first evaluates the overall financial impact (both on the hospitals and on the paying public) in FY 2011. Staff also has prepared a longer term analysis that attempts to extrapolate the magnitude of each Update Option out over a period of time. Each Option carries with its own set of implications – which can be viewed in the context of multiple years relative to projected national Medicare Updates (as specified by current law) and relative to likely increases in US hospital payments over time. In this longer term context, these simulations can then be used to evaluate the long term impact on the Maryland Waiver Test and the affordability of the Maryland Hospital system relative to hospital care nationally. They can also show the impact certain payment trajectories can have on "bending the cost curve" in Maryland and the system savings that can result vis-à-vis what is likely to be experienced outside of Maryland. While staff is not intending to recommend adoption of any of these Update Options beyond FY 2011, it believes that this longer term context will be helpful to the Commission in its determination of where it believes the Rate Setting System should move over time.

FY 2011 Health Care Cost Impact

It should be noted that in addition to volume increases, the paying public will also see increases in hospital rates in FY 2011 due to the following factors: 1) increased markups of rates due to increases in uncompensated care provisions of hospitals n FY 2011 of 0.44%; 2) a uniform assessment of 0.64% on hospital rates associated with the Medicaid budget shortfalls in FY 2011; 3) an increase in rates of approximately $29 million or about 0.21% due to the restoration of lost case mix by hospitals who opened medical observation units.

Table 21 summarizes the net impact on the paying public of these increases to rates under each Payment Update Scenario shown in **Table 20**. The net increase to costs for the Maryland health care system as a result of the FY 2011hospital Payment Update and other related factors ranges from 3.16% increase in hospital payments or approximately $426 million (in the case of Option 1) up to 5.36% increase in overall hospital payments or approximately $723 million (in the case of the MHA proposal). This represents a difference of just under $300 million of additional health care expenditures in FY 2011 between the high and the low option.

Table 22

Net Impact on Paying Public of each Option

Full Impact of Each Option	**Option 1** No-Erosion on Waiver	**Option 2** Payer Proposal	**Option 3** Target 6.0% Below US by 2015	**Option 4** "Peg Medicaid"	**Option 5** MHA Proposal
Full Update Provided	**0.77%**	**1.58%**	**1.91%**	**2.05%**	**2.97%**
Estimated Volume Increase	1.10%	1.10%	1.10%	1.10%	1.10%
Subtotal Revenue Increase	1.87%	2.68%	3.01%	3.15%	4.07%
Markup Increase	0.44%	0.44%	0.44%	0.44%	0.44%
Medicaid Assessment	0.64%	0.64%	0.64%	0.64%	0.64%
Early Adopter CMI Restoration	0.21%	0.21%	0.21%	0.21%	0.21%
Overall increase to Hospital charges	**3.16%**	**3.97%**	**4.30%**	**4.44%**	**5.36%**
Additional 2011 Expenditures	$426 mill.	$535 mil	$580 mill.	$599 mill.	$723 mill.

Estimated Financial Impact of Update Options

Staff also prepared an estimate of the potential impact on the overall financial profitability of the Maryland hospital industry in FY 2011 (using on 10 months of FY 2010 system financial experience as a base). This estimate assumes historical growth and applies current estimates for increases in underlying hospital cost inflation (2.67% in FY 2011 which consists of a 2.29% increase in factor costs – as projected by the Global Insights Market Basket plus an historical forecast error 0.38%). The estimate also assumes that unregulated losses (particularly physician part B losses) continue to increase at historical rates. The staff analysis presents projected industry operating profitability assuming various scenarios of cost constraint by hospitals: Scenario 1: no constraint of the 2.67% expense growth (i.e., no productivity improvement) and no reduction of Physician Part B losses; Scenario 2: a modest 0.5% improvement in operating efficiency (i.e., costs grow at 2.17% instead of 2.67%) and a 5% reduction in Physician Part B expenses vs. 2010; and Scenario 3: a 1.0% improvement in productivity (cost growth of 1.67% vs. 2.67%) and a 10% reduction in Physician Part B losses. **Table 23** presents the results of these different Profitability Scenarios on Total Operating Margins in FY 2011. The Table also shows the level of Regulated Operating Margin for each Scenario. Given this highly favorable regulated level of profitability, productivity improvement, coupled with concerted efforts to reduce unnecessary expenditures on Physicians can result in considerable improvement to overall operating margins if Maryland hospitals improve their productivity by 0.5% to 1.0% and if they can simultaneously stem the tide on growing physician losses in the industry. The detailed assumptions and calculation of these profitability estimates are contained in **Appendix II.**

Table 23

Impact of Update Options under different Productivity and Physician Loss Scenarios

	No Erosion Update	Payer Update	Target 6% Update	Peg Medicaid Update	MHA Update
Scenario 1:	**Option 1**	**Option 2**	**Option 3**	**Option 4**	**Option 5**
No Productivity/No Reduction in Unregulated Loss					
Regulated Operating Margins	4.66%	5.41%	5.72%	5.85%	6.68%
Total Operating Margins	0.95%	1.67%	1.95%	2.08%	2.87%
Scenario 2:					
0.5% Productivity Gain/5% Reduction in Unregulated Loss					
Regulated Operating Margins	5.12%	5.87%	6.18%	6.30%	7.14%
Total Operating Margins	1.63%	2.34%	2.62%	2.75%	3.53%
Scenario 3:					
1.0% Productivity/10% Reduction in Unregulated Loss					
Regulated Operating Margins	5.59%	6.33%	6.64%	6.76%	7.59%
Total Operating Margins	2.30%	3.01%	3.29%	3.41%	4.20%

This analysis was presented and discussed at the Payment Work Group. Hospital representatives argued that the analysis did not consider amounts in excess of $100 million in additional depreciation and interest costs "scheduled" to be absorbed by hospitals in future years. Staff noted that these additional amounts were intended to be funded by the explicit additional (and unprecedented) 1-2% allowances afforded hospitals in the period FY 2004-2007. These amounts are in the hospitals' rate base now and were intended explicitly to facilitate the financing of capital projects. Additionally, many hospitals have sought incremental financing for capital projects by filing full or partial rate applications. Similarly, the staff expects other facilities to seek rate relief for capital expense through the future rate applications or the recently approved "advance funding of capital" policy in the context of this year's ROC Recommendation.

Estimated Impact of Update Options on System Affordability, Waiver Test, Overall State Savings and Medicaid Savings.

Staff also extrapolated the magnitude of each Update Option and corresponding financial impact over time, on: 1) Overall System Affordability (i.e., position of Maryland vs. the US through 2015); 2) Waiver Test impact; 3)

the Overall level of expenditure savings for the paying public in Maryland (vs. expenditures at US growth rates); and 4) the Overall level of savings for the Medicaid Program. The results of these analyses are shown below in Tables 22 – 26 and in Charts 4 -8. Detailed assumptions and projection models along with assumptions regarding national Medicare and US hospital revenue and expenditure rates of growth are contained in **Appendix III.**

Intent of the Multi-Year Analysis

As indicated, the current Rate Update Proposals and Options are for one year only (FY 2011). No party is advocating a multi-year payment arrangement beyond FY 2011. The intent of these simulations is to put in a longer term context, the implication of the Commission adopting each of the proposed Update Options, extrapolated out over a period of time. Projections of this nature were also necessary to develop a recommended trajectory for the Rate Setting System to reach the Staff recommended target of 6.0% below the US on cost per EIPA.

The MHA has indicated support for a future limitation on for the Rate System via enforcement of the Waiver "trip-wire." The Payers have indicated that once a position of 6.0% below the US on Net patient Revenue per EIPA is reached, that the Commission parallel the US average update, regardless of the impact on the Medicare waiver.

Table 24
Maryland Position on Cost per EIPA 2011 – 2015
Extrapolating each Update Option

Maryland Position vs. US (Cost per EIPA)

	FY10	FY11	FY12	FY13	FY14	FY15
MHA Proposal	-0.11%	-0.11%	-0.29%	-0.50%	-0.71%	-0.92%
Payer Proposal	-0.11%	-1.40%	-3.00%	-4.62%	-6.21%	-7.78%
Peg Medicaid	-0.11%	-0.96%	-2.02%	-3.09%	-4.16%	-5.21%
6.0% Target	-0.11%	-1.09%	-2.31%	-3.56%	-4.79%	**-6.00%**

Chart 6
Maryland Position on Cost per EIPA 2011 – 2015
Extrapolating each Update Option

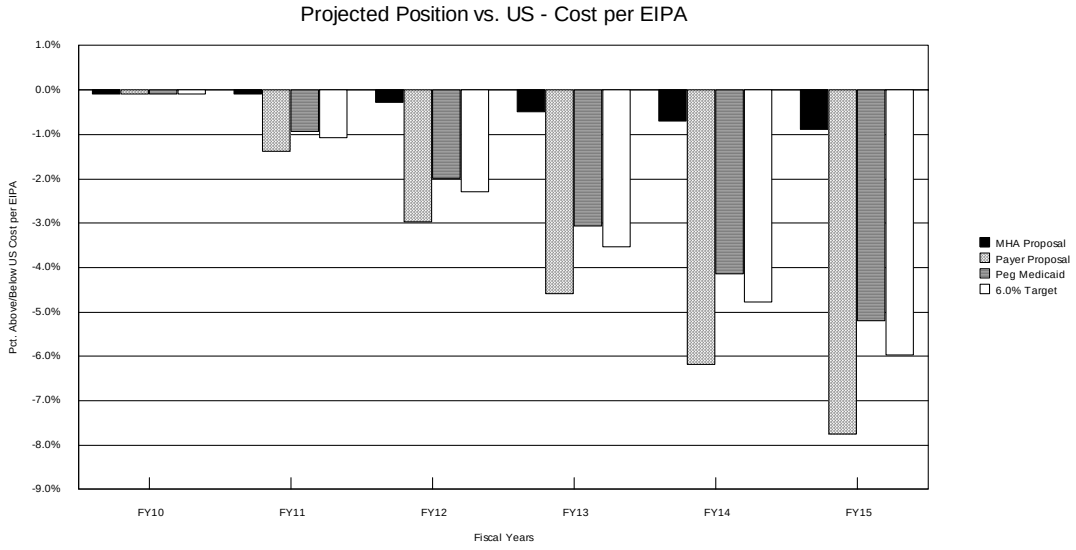


Table 25
Performance of the Maryland Medicare Waiver Cushion 2011-2019
Extrapolating each Update Option

Waiver Relative Cushion

	MHA	Payers	Peg Mcaid	6% Target
FY10	13.88%	13.88%	13.88%	13.88%
FY11	11.28%	12.54%	12.12%	12.01%
FY12	9.34%	12.03%	10.70%	10.90%
FY13	6.77%	10.91%	9.01%	9.16%
FY14	4.77%	10.35%	7.89%	8.00%
FY15	2.03%	9.06%	6.02%	6.09%
FY16	1.54%	10.02%	6.42%	6.43%
FY17	1.29%	11.22%	7.06%	7.02%
FY18	**0.00%**	11.38%	6.65%	6.57%
FY19	-1.07%	11.76%	6.46%	6.33%

Chart 7
Performance of the Maryland Medicare Waiver Cushion 2011-2019
Extrapolating each Update Option

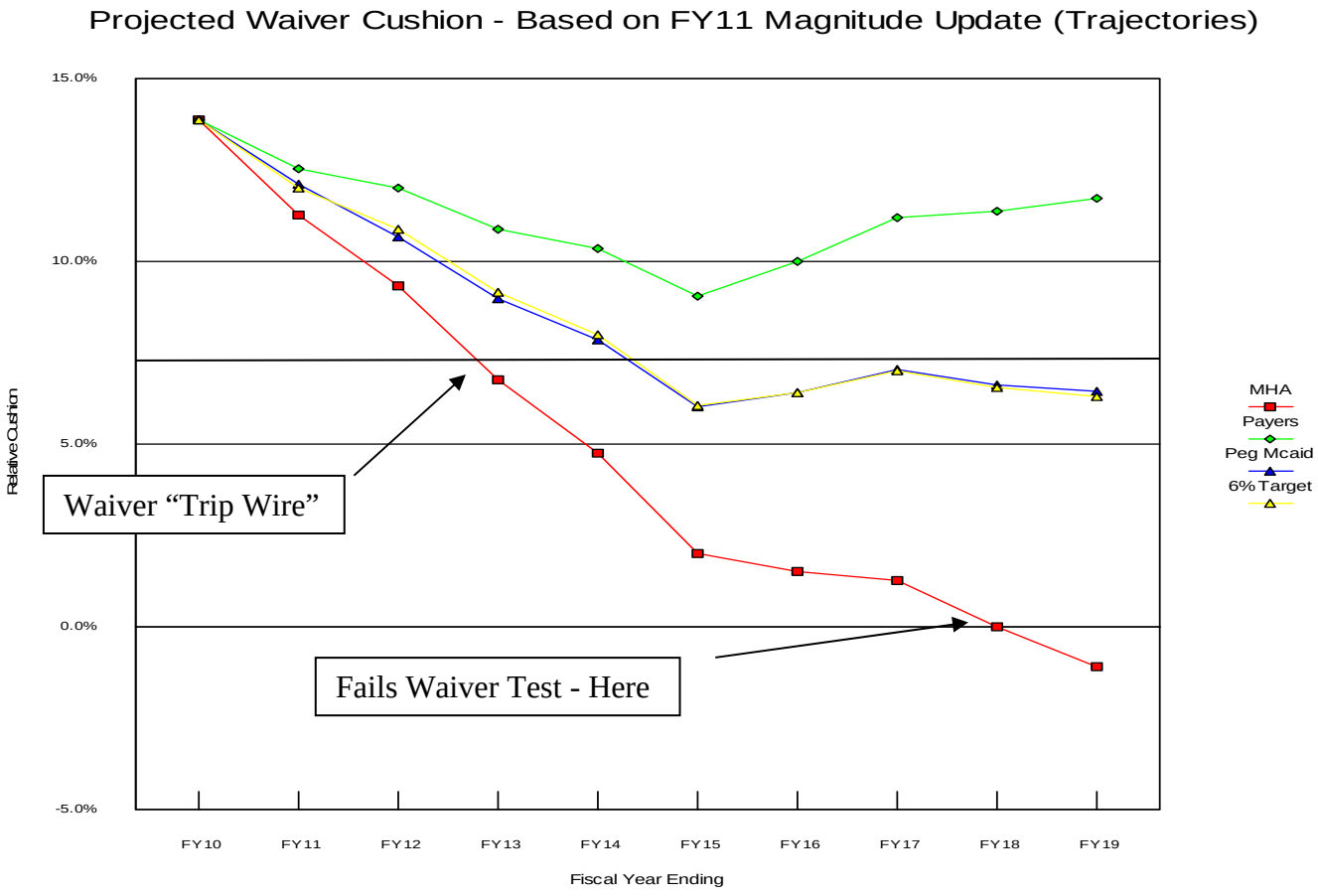


Table 26

Projected Hospital Revenue (Public Expenditures on Hospital Care in Maryland) 2011 – 2019
Extrapolating each Update Option

Projected Payment Levels - under different Trajectories
(Millions $)

	FY10	FY11	FY12	FY13	FY14	FY15	FY16	FY17	FY18	FY19
US Payment Growth Rate	$11,969	$12,532	$13,221	$13,964	$14,750	$15,580	$16,456	$17,382	$18,360	$19,392
MHA Trajectory	$11,969	$12,525	$13,179	$13,880	$14,618	$15,396	$16,215	$17,077	$17,986	$18,943
Payer Trajectory	$11,969	$12,358	$12,811	$13,290	$13,786	$14,301	$14,835	$15,389	$15,963	$16,559
Medicaid Peg Trajectory	$11,969	$12,415	$12,944	$13,508	$14,096	$14,710	$15,350	$16,018	$16,716	$17,444
6% Target Trajectory	$11,969	$12,398	$12,904	$13,441	$14,001	$14,584	$15,192	$15,825	$16,484	$17,170

Chart 8

"**Bending the Cost Curve**"
Projected Hospital Revenue (Public Expenditures on Hospital Care in Maryland) 2011 – 2019
Extrapolating each Update Option

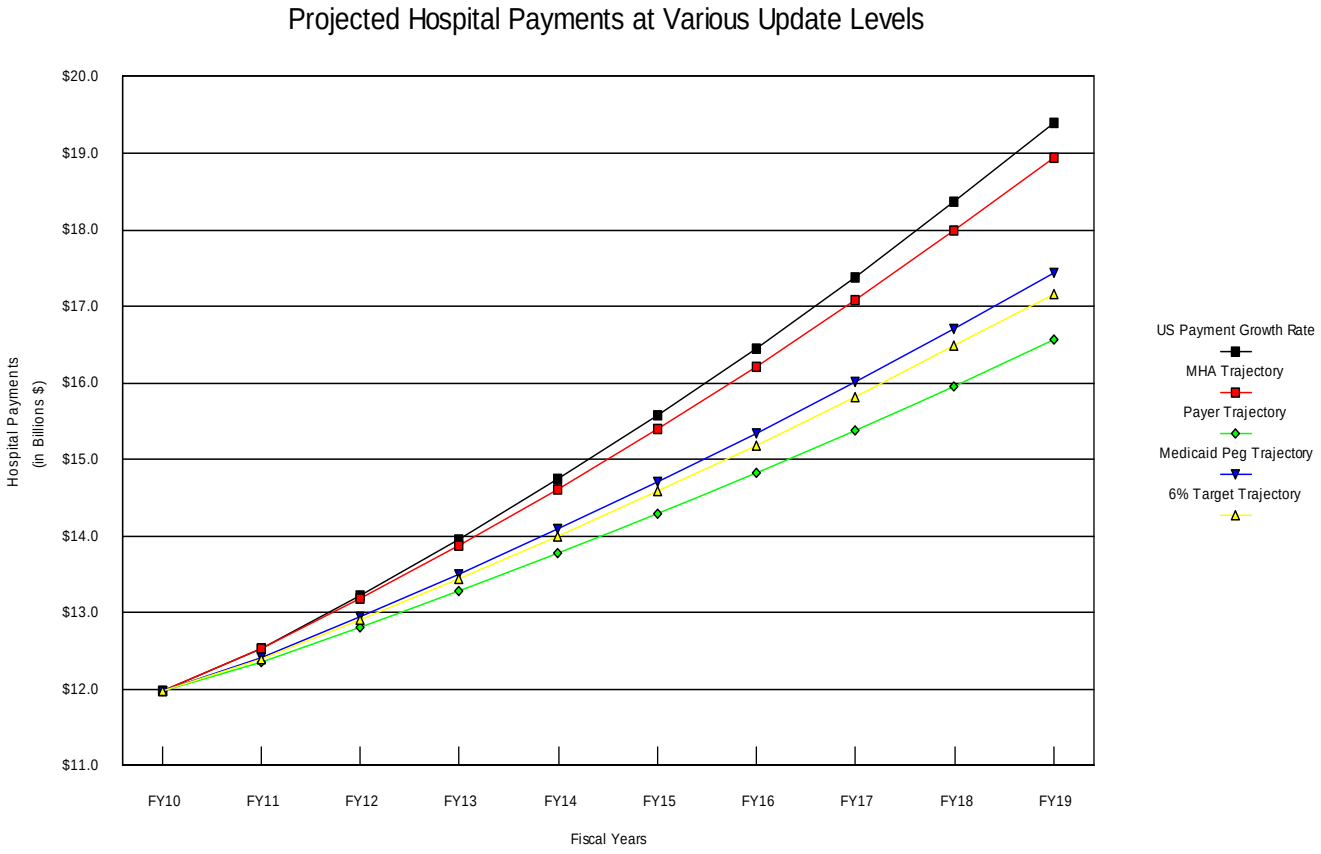


Table 27
Overall Cumulative State Savings (Reduced Hospital Expenditures)
Relative to US Rates of Growth

Annual Cost Savings vs. US Growth Rate
Millions $

	FY10	FY11	FY12	FY13	FY14	FY15	FY16	FY17	FY18	FY19	Cumulative
US Payment Growth Rate	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	
MHA Savings	$0	$8	$43	$86	$134	$188	$246	$310	$381	$458	$1,855
Payer Savings	$0	$177	$417	$688	$982	$1,303	$1,652	$2,031	$2,442	$2,887	$12,581
Medicaid Peg Savings	$0	$120	$282	$465	$667	$887	$1,127	$1,390	$1,675	$1,986	$8,599
6% Target Savings	$0	$137	$323	$533	$763	$1,014	$1,289	$1,587	$1,912	$2,265	$9,823

Chart 9
Overall Cumulative State Savings (Reduced Hospital Expenditures)
Relative to US Rates of Growth

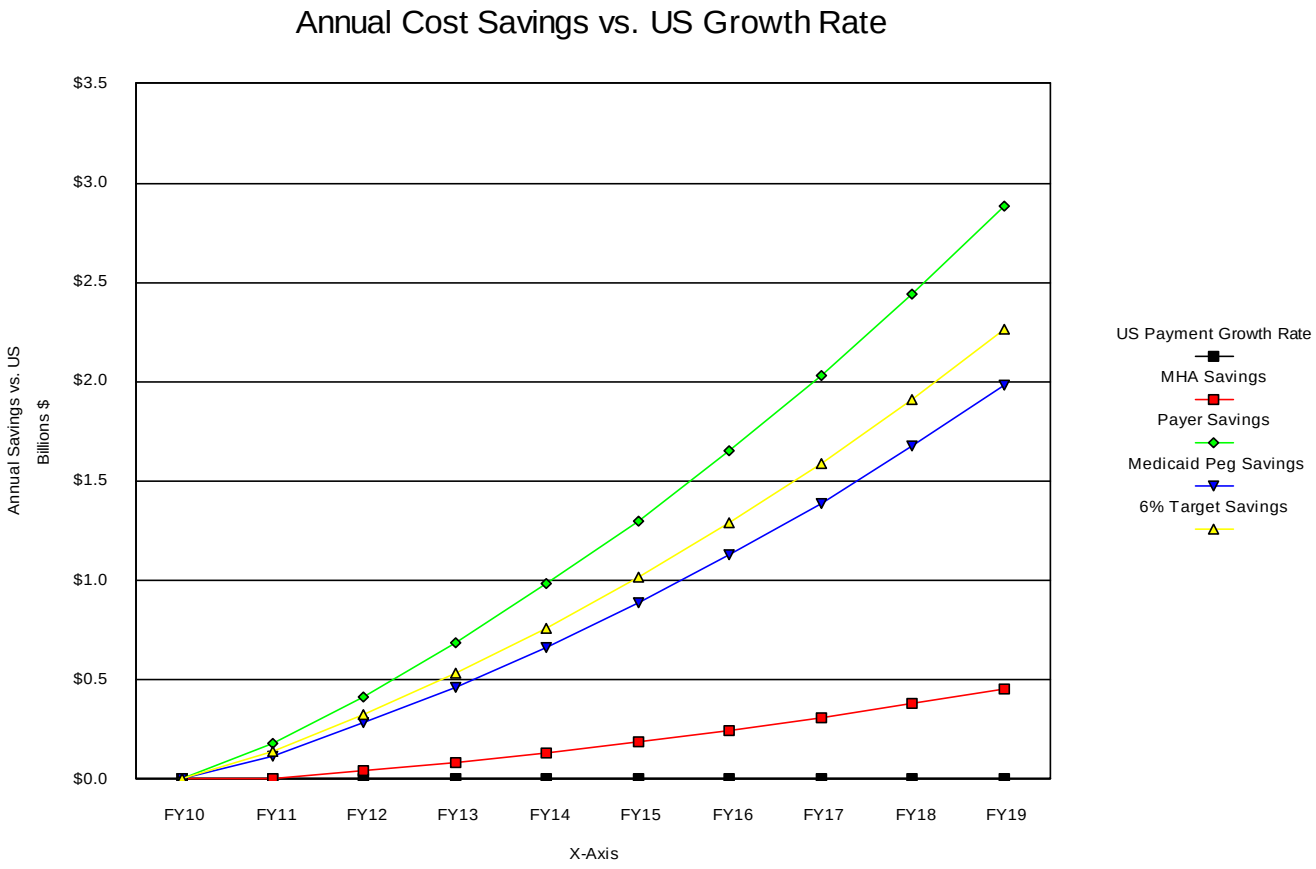


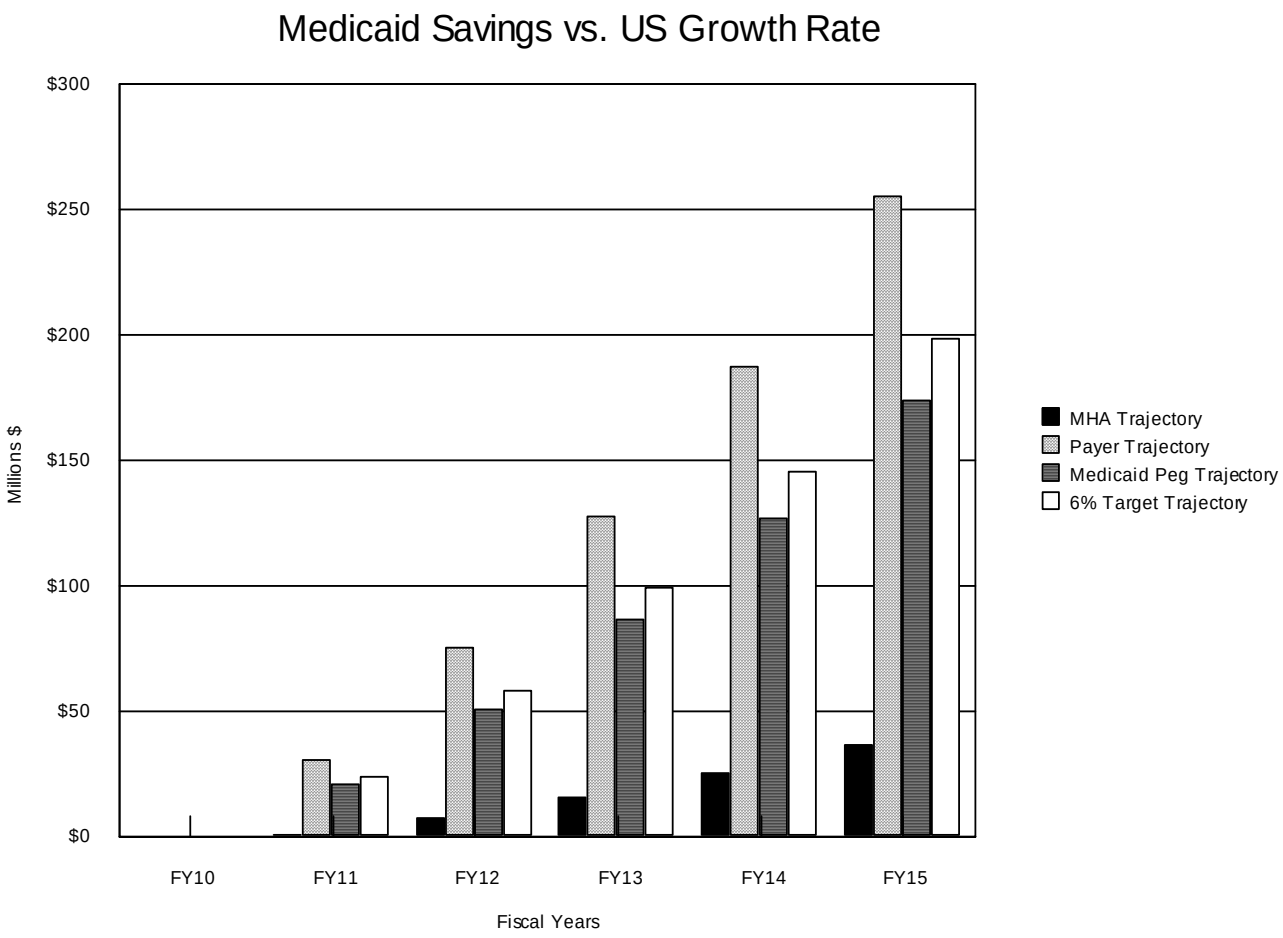
Table 28
Overall Cumulative State Medicaid Savings (Reduced Payments to Hospitals)
Relative to US Rates of Growth

Medicaid Savings vs. US Growth Rate

Millions $

	FY10	FY11	FY12	FY13	FY14	FY15	Cumulative Savings
MHA Trajectory	$0	$1	$8	$16	$26	$37	**$88**
Payer Trajectory	$0	$31	$76	$128	$188	$256	**$679**
Medicaid Peg Trajectory	$0	$21	$51	$87	$128	$174	**$461**
6% Target Trajectory	$0	$24	$59	$99	$146	$199	**$527**

Chart 10
Overall Cumulative State Medicaid Savings (Reduced Payments to Hospitals)
Relative to US Rates of Growth



Summary of Overall Impacts

The following tables summarize the impacts of each Update Option extrapolated out over a long-term time frame. The intent of this analysis is to show the implications of each Option in the context of the future health care financing environment.

Table 29a-d

Summary of Long Term System Impacts

MHA, Payer, Medicaid, 6.0% Cost Target Options Extrapolated out over the period 2011-2019 relative to Projected US Medicare and All-Payer Growth Rates

Summary of Results: MHA Proposal

Line	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Avg Chg.
37 Outperform US (positive=outperform)		-0.06%	-0.27%	-0.31%	-0.31%	-0.31%	-0.31%	-0.31%	-0.31%	-0.31%	-0.27%
38 Waiver Erosion		-2.60%	-1.93%	-2.57%	-2.00%	-2.74%	-0.49%	-0.24%	-1.29%	-1.07%	-1.66%
39 MD Net Patient Revenue	$11,969	$12,525	$13,179	$13,880	$14,618	$15,396	$16,215	$17,077	$17,986	$18,943	
40 MD Total Operating Cost (Mill $)	$12,199	$12,765	$13,431	$14,146	$14,898	$15,691	$16,525	$17,405	$18,330	$19,306	5 yr saving
41 Cost Savings vs US Growth (Mill $)		$8	$43	$86	$134	$188	$246	$310	$381	$458	$459
(negative numbers = dissavings)											9 yr saving
42 Position vs. US Cost/EIPA						-0.92%					$1,855
43 Medicaid Share	17.50%	18.00%	18.50%	19.00%	19.50%	20.00%	20.00%	20.00%	20.00%	20.00%	
44 Medicaid Pmts	$2,095	$2,254	$2,438	$2,637	$2,851	$3,079	$3,243	$3,415	$3,597	$3,789	5 yr saving
45 Savings vs. US Growth	$0	$1	$8	$16	$26	$37	$48	$61	$75	$90	$88
46 **Waiver Cushion**	**13.88%**	**11.28%**	**9.34%**	**6.77%**	**4.77%**	**2.03%**	**1.54%**	**1.29%**	**0.00%**	**-1.07%**	
47 **Cost per EIPA Position vs US**	**-0.11%**	**-0.11%**	**-0.29%**	**-0.50%**	**-0.71%**	**-0.92%**	**-1.13%**	**-1.34%**	**-1.55%**	**-1.55%**	

Summary of Results: Payer Proposal

Line	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Avg Chg.
37 Outperform US (positive=outperform)		-1.45%	-1.83%	-1.89%	-1.89%	-1.89%	-1.89%	-1.89%	-1.89%	-1.89%	-1.84%
38 Waiver Erosion		-1.33%	-0.51%	-1.12%	-0.55%	-1.29%	0.96%	1.21%	0.16%	0.38%	-0.24%
39 Net Patient Revenue	$11,969	$12,358	$12,811	$13,290	$13,786	$14,301	$14,835	$15,389	$15,963	$16,559	
40 Total Operating Cost (Mill $)	$12,199	$12,595	$13,057	$13,544	$14,050	$14,575	$15,119	$15,684	$16,269	$16,877	5 yr saving
41 Cost Savings vs US Growth (Mill $)		$177	$417	$688	$982	$1,303	$1,652	$2,031	$2,442	$2,887	$3,568
(negative numbers = dissavings)											9 yr saving
42 Position vs US Cost/EIPA						-7.78%					$12,581
43 Medicaid Share	17.50%	18.00%	18.50%	19.00%	19.50%	20.00%	20.00%	20.00%	20.00%	20.00%	
44 Medicaid Pmts	$2,095	$2,225	$2,370	$2,525	$2,688	$2,860	$2,967	$3,078	$3,193	$3,312	5 yr saving
45 Savings vs. US Growth	$0	$31	$76	$128	$188	$256	$324	$399	$479	$567	$679
46 **Waiver Cushion**	**13.88%**	**12.54%**	**12.03%**	**10.91%**	**10.35%**	**9.06%**	**10.02%**	**11.22%**	**11.38%**	**11.76%**	
47 **Cost per EIPA Position vs US**	**-0.11%**	**-1.40%**	**-3.00%**	**-4.62%**	**-6.21%**	**-7.78%**	**-9.32%**	**-10.84%**	**-12.33%**	**-12.33%**	

Summary of Results: Peg Medicaid Budget Update

Line	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Avg Chg.
37 Outperform US (positive=outperform)		-0.98%	-1.23%	-1.27%	-1.27%	-1.27%	-1.27%	-1.27%	-1.27%	-1.27%	-1.23%
38 Waiver Erosion		-1.76%	-1.42%	-1.69%	-1.12%	-1.86%	0.39%	0.64%	-0.41%	-0.19%	-0.82%
39 Net Patient Revenue	$11,969	$12,415	$12,944	$13,508	$14,096	$14,710	$15,350	$16,018	$16,716	$17,444	
40 Total Operating Cost (Mill $)	$12,199	$12,652	$13,192	$13,766	$14,366	$14,991	$15,644	$16,325	$17,036	$17,778	5 yr saving
41 Cost Savings vs US Growth (Mill $)		$120	$282	$465	$667	$887	$1,127	$1,390	$1,675	$1,986	$2,421
(negative numbers = dissavings)											9 yr saving
42 Position vs US Cost/EIPA						-5.21%					$8,599
43 Medicaid Share	17.50%	18.00%	18.50%	19.00%	19.50%	20.00%	20.00%	20.00%	20.00%	20.00%	
44 Medicaid Pmts	$2,095	$2,235	$2,395	$2,566	$2,749	$2,942	$3,070	$3,204	$3,343	$3,489	5 yr saving
45 Savings vs. US Growth	$0	$21	$51	$87	$128	$174	$221	$273	$329	$390	$461
46 **Waiver Cushion**	**13.88%**	**12.12%**	**10.70%**	**9.01%**	**7.89%**	**6.02%**	**6.42%**	**7.06%**	**6.65%**	**6.46%**	
47 **Cost per EIPA Position vs US**	**-0.11%**	**-0.96%**	**-2.02%**	**-3.09%**	**-4.16%**	**-5.21%**	**-6.26%**	**-7.29%**	**-8.31%**	**-8.31%**	

Summary of Results: 6.0% Cost Target by 2015

Line	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Avg.
37 Outperform US (positive=outperform)		-1.12%	-1.41%	-1.46%	-1.46%	-1.46%	-1.46%	-1.46%	-1.46%	-1.46%	-1.42%
38 Waiver Erosion		-1.86%	-1.11%	-1.74%	-1.17%	-1.91%	0.34%	0.59%	-0.46%	-0.24%	-0.84%
39 Net Patient Revenue	$11,969	$12,398	$12,904	$13,441	$14,001	$14,584	$15,192	$15,825	$16,484	$17,170	
40 Total Operating Cost (Mill $)	$12,199	$12,635	$13,151	$13,699	$14,269	$14,864	$15,483	$16,128	$16,799	$17,499	/5 yr saving
41 Cost Savings vs US Growth (Mill $)		$137	$323	$533	$763	$1,014	$1,289	$1,587	$1,912	$2,265	$2,770
(negative numbers = dissavings)											9 yr savings
42 Position vs US Cost/EIPA						-5.96%					$9,823
43 Medicaid Share	17.50%	18.00%	18.50%	19.00%	19.50%	20.00%	20.00%	20.00%	20.00%	20.00%	
44 Medicaid Pmts	$2,095	$2,232	$2,387	$2,554	$2,730	$2,917	$3,038	$3,165	$3,297	$3,434	5 yr Savings
45 Savings vs. US Growth	$0	$24	$59	$99	$146	$199	$253	$311	$375	$444	$527
46 **Waiver Cushion**	**13.88%**	**12.01%**	**10.90%**	**9.16%**	**8.00%**	**6.09%**	**6.43%**	**7.02%**	**6.57%**	**6.33%**	
47 **Cost per EIPA Position vs US**	**-0.11%**	**-1.09%**	**-2.30%**	**-3.54%**	**-4.76%**	**-5.96%**	**-7.15%**	**-8.33%**	**-9.49%**	**-9.49%**	

The detailed assumptions and calculation of these impact estimates are contained in **Appendix III.**

Comparison of Scaling Proposals

Table 30 provides a comparison of the impact of the various scaling proposals from Payers, MHA and HSCRC staff. The detailed calculations of each scaling category (ROC, QBR and MHACs) are contained in **Appendix I.**

Table 30

Combined Scaling Results (MHA, Staff and Payer Options)

Summary of Scaling Proposals

	MHA Combined	Staff Combined	Payer Combined
210010 Dorchester General Hospital	1.12%	1.75%	2.38%
210017 Garrett County Memorial Hospital	1.18%	1.66%	2.14%
210037 Memorial Hospital at Easton	1.00%	1.45%	1.90%
210005 Frederick Memorial Hospital	0.86%	1.18%	1.50%
210039 Calvert Memorial Hospital	0.76%	1.03%	1.31%
210038 Maryland General Hospital	0.85%	1.05%	1.25%
210001 Washington County Hospital	0.52%	0.85%	1.18%
210023 Anne Arundel Medical Center	0.47%	0.74%	1.02%
210032 Union of Cecil	0.45%	0.71%	0.97%
210034 Harbor Hospital Center	0.50%	0.71%	0.93%
210008 Mercy Medical Center	0.62%	0.76%	0.90%
210015 Franklin Square Hospital Center	0.45%	0.54%	0.64%
210060 Fort Washington	0.51%	0.52%	0.52%
210033 Carroll Hospital Center	0.38%	0.43%	0.48%
210029 Johns Hopkins Bayview Medical Center	0.24%	0.33%	0.42%
210004 Holy Cross Hospital	0.23%	0.30%	0.37%
210045 McCready Memorial Hospital	0.36%	0.36%	0.36%
210011 St. Agnes Hospital	0.16%	0.22%	0.27%
210043 Baltimore Washington Medical Center	0.15%	0.19%	0.22%
210056 Good Samaritan Hospital	0.10%	0.15%	0.19%
210019 Peninsula Regional Medical Center	0.17%	0.17%	0.16%
210057 Shady Grove Adventist Hospital	0.01%	0.06%	0.11%
210013 Bon Secours Hospital	0.04%	0.04%	0.04%
210024 Union Memorial Hospital	0.12%	0.07%	0.03%
210035 Civista Medical Center	-0.22%	-0.12%	-0.03%
210028 St. Mary's Hospital	0.01%	-0.07%	-0.15%
210027 Western MD (estimated)	-0.05%	-0.11%	-0.16%
210044 GBMC	0.02%	-0.07%	-0.17%
210049 Upper Chesapeake Medical Center	-0.09%	-0.14%	-0.19%
210054 Southern Maryland Hospital Center	0.04%	-0.12%	-0.28%
210007 St. Joseph Medical Center	-0.14%	-0.24%	-0.35%
210058 James Lawrence Kernan Hospital	-0.07%	-0.22%	-0.36%
210002 University of Maryland Hospital	-0.42%	-0.42%	-0.42%
210022 Suburban Hospital	-0.17%	-0.30%	-0.43%
210012 Sinai Hospital	-0.35%	-0.45%	-0.56%
210048 Howard County General Hospital	-0.38%	-0.47%	-0.56%
210061 Atlantic General Hospital	-0.26%	-0.44%	-0.63%
210040 Northwest Hospital Center	-0.30%	-0.48%	-0.66%
210009 Johns Hopkins Hospital	-0.37%	-0.52%	-0.68%
210018 Montgomery General Hospital	-0.31%	-0.51%	-0.72%
210006 Harford Memorial Hospital	-0.45%	-0.63%	-0.81%
210016 Washington Adventist Hospital	-0.54%	-0.68%	-0.82%
210003 Prince Georges Hospital Center	-0.73%	-0.82%	-0.90%
210030 Chester River Hospital Center	-0.83%	-0.98%	-1.14%
210055 Laurel Regional Hospital	-0.73%	-0.95%	-1.17%
210051 Doctors Community Hospital	-1.02%	-1.26%	-1.49%

Note: Although this is not shown in this simulation, all parties agree that combined negative scaling for any hospital should be limited to the magnitude of the base update approved by the Commission (MB + Forecast error + Policy Adjustment + Slippage)

Additionally - there is agreement that the scaling should be revenue neutral and that any reduction in a given hospital's negative scaling be redistributed to all other negatively scaled hospitals to reduce the amount of their offset.

Staff Recommendations

1) Update Options and Staff Recommendation

The following table presents all five Update Options and estimated waiver test, cost and financial impacts.

Summary of Update Options	**Option 1** Steady on Waiver Test	**Option 2** Payer Proposal	**Option 3** Update for trajectory to a position of 6.0% below US Cost/EIPA	**Option 4** Peg" Medicaid Budgeted Update	**Option 5** MHA Proposal
Global Insight's - 1st Qtr Book for RY 6/30/11	2.29%	2.29%	2.29%	2.29%	2.29%
Inflation Forecast Error	0.38%	0.38%	0.38%	0.38%	0.38%
Subtotal Inflation Allowance	2.67%	2.67%	2.67%	2.67%	2.67%
Policy Adjustment (Improvement to US)	-2.68%	-1.87%	-1.54%	-1.40%	-0.48%
Subtotal Update	-0.01%	0.80%	1.13%	1.27%	2.19%
Slippage For RY 2010	0.03%	0.03%	0.03%	0.03%	0.03%
Rate Update Provided	0.02%	0.83%	1.16%	1.30%	2.22%
Volume Adjustment (RY 2010 over RY 2009)	-0.23%	-0.23%	-0.23%	-0.23%	-0.23%
CMI Adjustment (Lower of Actual or Limit)	0.98%	0.98%	0.98%	0.98%	0.98%
Full Update Provided	**0.77%**	**1.58%**	**1.91%**	**2.05%**	**2.97%**
Estimated Volume Increase	1.10%	1.10%	1.10%	1.10%	1.10%
Overall Revenue Increase	1.87%	2.68%	3.01%	3.15%	4.07%
Overall Hospital Charge Increase *	3.16%	3.97%	4.30%	4.44%	5.36%

* includes 0.44 markup, .21 ODS adjustment and .64% Medicaid Assessment

Summary Results:					
Regulated Profit w/ 0.5 Productivity	5.12%	5.87%	6.18%	6.30%	7.14%
Total Op Profit w/ 0.5 Productivity & 5% less in physician loss	1.63%	2.34%	2.62%	2.75%	3.53%
Trajectory Cost Position vs. US FY 15	-13.55%	-7.78%	-6.00%	-5.21%	-0.92%
Waiver Cushion FY 2015	13.88%	9.06%	6.09%	6.02%	2.03%
Fail Waiver	Never	20+ Years	15 Years	17 Years	7 Years
Medicaid Savings vs. US Growth Rate FY 2015		$679 Mill.	$527 Mill.	$461 Mill.	$88 Mill.
System Savings vs. US Growth Rate 5 years to FY 2015		$3,568 Mill.	$2,786 Mill.	$2,421 Mill.	$459 Mill.

Staff recommends the Commission adopt a goal of moving the Rate Setting System toward a position of 6.0% below the US on the basis of hospital cost per EIPA as derived from data published by the American Hospital Association in their annual statistical guide.

Staff believes the Update Option 3 (6.0% Target Option) strikes the best balance between maintaining adequate cost constraint and financial condition and therefore recommends the adoption of a 1.91% payment update for FY 2011.

2) Scaling Options and Staff Recommendation

The following table presents a comparison of the three options for scaling:

Summary of Scaling Proposals

	MHA **Combined**	Staff **Combined**	Payer **Combined**
210010 Dorchester General Hospital	1.12%	1.75%	2.38%
210017 Garrett County Memorial Hospital	1.18%	1.66%	2.14%
210037 Memorial Hospital at Easton	1.00%	1.45%	1.90%
210005 Frederick Memorial Hospital	0.86%	1.18%	1.50%
210039 Calvert Memorial Hospital	0.76%	1.03%	1.31%
210038 Maryland General Hospital	0.85%	1.05%	1.25%
210001 Washington County Hospital	0.52%	0.85%	1.18%
210023 Anne Arundel Medical Center	0.47%	0.74%	1.02%
210032 Union of Cecil	0.45%	0.71%	0.97%
210034 Harbor Hospital Center	0.50%	0.71%	0.93%
210008 Mercy Medical Center	0.62%	0.76%	0.90%
210015 Franklin Square Hospital Center	0.45%	0.54%	0.64%
210060 Fort Washington	0.51%	0.52%	0.52%
210033 Carroll Hospital Center	0.38%	0.43%	0.48%
210029 Johns Hopkins Bayview Medical Center	0.24%	0.33%	0.42%
210004 Holy Cross Hospital	0.23%	0.30%	0.37%
210045 McCready Memorial Hospital	0.36%	0.36%	0.36%
210011 St. Agnes Hospital	0.16%	0.22%	0.27%
210043 Baltimore Washington Medical Center	0.15%	0.19%	0.22%
210056 Good Samaritan Hospital	0.10%	0.15%	0.19%
210019 Peninsula Regional Medical Center	0.17%	0.17%	0.16%
210057 Shady Grove Adventist Hospital	0.01%	0.06%	0.11%
210013 Bon Secours Hospital	0.04%	0.04%	0.04%
210024 Union Memorial Hospital	0.12%	0.07%	0.03%
210035 Civista Medical Center	-0.22%	-0.12%	-0.03%
210028 St. Mary's Hospital	0.01%	-0.07%	-0.15%
210027 Western MD (estimated)	-0.05%	-0.11%	-0.16%
210044 GBMC	0.02%	-0.07%	-0.17%
210049 Upper Chesapeake Medical Center	-0.09%	-0.14%	-0.19%
210054 Southern Maryland Hospital Center	0.04%	-0.12%	-0.28%
210007 St. Joseph Medical Center	-0.14%	-0.24%	-0.35%
210058 James Lawrence Kernan Hospital	-0.07%	-0.22%	-0.36%
210002 University of Maryland Hospital	-0.42%	-0.42%	-0.42%
210022 Suburban Hospital	-0.17%	-0.30%	-0.43%
210012 Sinai Hospital	-0.35%	-0.45%	-0.56%
210048 Howard County General Hospital	-0.38%	-0.47%	-0.56%
210061 Atlantic General Hospital	-0.26%	-0.44%	-0.63%
210040 Northwest Hospital Center	-0.30%	-0.48%	-0.66%
210009 Johns Hopkins Hospital	-0.37%	-0.52%	-0.68%
210018 Montgomery General Hospital	-0.31%	-0.51%	-0.72%
210006 Harford Memorial Hospital	-0.45%	-0.63%	-0.81%
210016 Washington Adventist Hospital	-0.54%	-0.68%	-0.82%
210003 Prince Georges Hospital Center	-0.73%	-0.82%	-0.90%
210030 Chester River Hospital Center	-0.83%	-0.98%	-1.14%
210055 Laurel Regional Hospital	-0.73%	-0.95%	-1.17%
210051 Doctors Community Hospital	-1.02%	-1.26%	-1.49%

Note: Although this is not shown in this simulation, all parties agree that combined negative scaling for any hospital should be limited to the magnitude of the base update approved by the Commission (MB + Forecast error + Policy Adjustment + Slippage)

Additionally - there is agreement that the scaling should be revenue neutral and that any reduction in a given hospital's negative scaling be redistributed to all other negatively scaled hospitals to reduce the amount of their offset.

Staff recommends the Commission scaling of relative hospital performance based on the Commission's QBR, MHAC and ROC methodologies per the methodology simulated in the "Staff Combined" option shown in the above table and described as follows:

a) 0.5% of hospital approved revenue for QBR relative performance;

b) 0.5% of hospital approved revenue for MHAC relative performance;[11]

c) 15% of the difference between a hospital's position on the ROC and the peer group average (i.e., the peer group average = 0%);

d) although it is not represented in the above simulation – staff recommends limiting any given hospitals combined negative scaling to the magnitude of the Commission-approved base update for FY 2011 (i.e., Market Basket plus forecast error plus policy adjustment plus slippage).

e) additionally, the scaling would be calculated to be revenue neutral for the system as a whole and any additional amounts generated as a result of the above limitation on negative scaling, be reallocated to all other negatively scaled hospitals (as reductions to their calculated offsets).

f) Staff would further recommend that hospitals should not be entitled to both scaling and a full rate review and two hospitals be exempt from ROC scaling (McCready Hospital because it is a TPR hospital that is above the ROC average and Bon Secours because of financial issues).

g) In lieu of an aggressive scaling proposal, per the ROC approved recommendations, staff would pursue spenddown agreements with all high-cost hospitals (those more than 3.0% above their peer group average).

3) Other Recommendations

a) Saving Maryland Medicaid Expenditures

After performing a review of Maryland Medicaid payment methods for Washington DC hospitals, the HSCRC staff concluded that the Maryland Medicaid payment arrangement with Washington DC hospitals appears reasonable with one exception. Staff concluded that the current payment arrangement between the Maryland Medicaid program and Children's Hospital of Washington DC is excessive due to the inclusion of a negotiated extra factor in the hospital's payment formula. The Department's regulation currently authorizes an extra payment multiple for Children's Hospital of 2.5 x Children's reported Uncompensated Care. All other Washington DC hospitals are paid at a multiple of 1.0 x reported Uncompensated Care. This extra payment multiple will result in approximately $4 - 5 million in excessive and unnecessary payments by Maryland Medicaid to Children's Hospital in FY 2011. With the advent of the Medicaid Budget Assessments in FY 2010 and FY 2011, the existence of

[11] This simulation presents highly favorable results for Ft. Washington, however, based on the preliminary results of a routine case mix data audit staff may recommend excluding Ft. Washington from the MHAC analysis due to substantial inaccuracies in its coding of the Present on Admission (POA) Indicator. The staff plans to meet with the hospital and discuss the results and will present the results of its findings (and a recommendation whether to retain Ft. Washington in the analysis) to the Commission at a later date.

excessive Maryland Medicaid payments to out of state providers means that Maryland Hospitals and Payers are forced to subsidize these amounts.

Elimination of this multiple would reduce the assessments currently imposed on Maryland hospitals and payers.

Staff suggested that the Payment Work Group make a joint recommendation to Medicaid to change their reimbursement formula for Children's Hospital of DC to adjust this factor to 1.0 (the same as exists for all other District providers). Payer members representing CareFirst, Kaiser, and United Healthcare agreed with this recommendation. The Maryland Hospital Association did not support the staff recommendation. Staff contacted Children's representatives and indicated they could have time at the May 20th meeting of the Payment Work Group to respond to these recommendations. These representatives, however, declined to participate.

Staff recommends that the Commission send a letter to the Maryland Secretary of Health recommending this change to Maryland Medicaid reimbursement methodologies. The reductions of these unnecessary payments will thus go to reduce the $123 million assessment to be imposed on Maryland hospitals and payers in FY 2011.

Appendix I – Scaling Proposals Simulated (MHA, Payer and Staff)

Comparison of Scaling Proposals

Summary of Scaling Proposals

	MHA Combined	Staff Combined	Payer Combined
210010 Dorchester General Hospital	1.12%	1.75%	2.38%
210017 Garrett County Memorial Hospital	1.18%	1.66%	2.14%
210037 Memorial Hospital at Easton	1.00%	1.45%	1.90%
210005 Frederick Memorial Hospital	0.86%	1.18%	1.50%
210039 Calvert Memorial Hospital	0.76%	1.03%	1.31%
210038 Maryland General Hospital	0.85%	1.05%	1.25%
210001 Washington County Hospital	0.52%	0.85%	1.18%
210023 Anne Arundel Medical Center	0.47%	0.74%	1.02%
210032 Union of Cecil	0.45%	0.71%	0.97%
210034 Harbor Hospital Center	0.50%	0.71%	0.93%
210008 Mercy Medical Center	0.62%	0.76%	0.90%
210015 Franklin Square Hospital Center	0.45%	0.54%	0.64%
210060 Fort Washington	0.51%	0.52%	0.52%
210033 Carroll Hospital Center	0.38%	0.43%	0.48%
210029 Johns Hopkins Bayview Medical Center	0.24%	0.33%	0.42%
210004 Holy Cross Hospital	0.23%	0.30%	0.37%
210045 McCready Memorial Hospital	0.36%	0.36%	0.36%
210011 St. Agnes Hospital	0.16%	0.22%	0.27%
210043 Baltimore Washington Medical Center	0.15%	0.19%	0.22%
210056 Good Samaritan Hospital	0.10%	0.15%	0.19%
210019 Peninsula Regional Medical Center	0.17%	0.17%	0.16%
210057 Shady Grove Adventist Hospital	0.01%	0.06%	0.11%
210013 Bon Secours Hospital	0.04%	0.04%	0.04%
210024 Union Memorial Hospital	0.12%	0.07%	0.03%
210035 Civista Medical Center	-0.22%	-0.12%	-0.03%
210028 St. Mary's Hospital	0.01%	-0.07%	-0.15%
210027 Western MD (estimated)	-0.05%	-0.11%	-0.16%
210044 GBMC	0.02%	-0.07%	-0.17%
210049 Upper Chesapeake Medical Center	-0.09%	-0.14%	-0.19%
210054 Southern Maryland Hospital Center	0.04%	-0.12%	-0.28%
210007 St. Joseph Medical Center	-0.14%	-0.24%	-0.35%
210058 James Lawrence Kernan Hospital	-0.07%	-0.22%	-0.36%
210002 University of Maryland Hospital	-0.42%	-0.42%	-0.42%
210022 Suburban Hospital	-0.17%	-0.30%	-0.43%
210012 Sinai Hospital	-0.35%	-0.45%	-0.56%
210048 Howard County General Hospital	-0.38%	-0.47%	-0.56%
210061 Atlantic General Hospital	-0.26%	-0.44%	-0.63%
210040 Northwest Hospital Center	-0.30%	-0.48%	-0.66%
210009 Johns Hopkins Hospital	-0.37%	-0.52%	-0.68%
210018 Montgomery General Hospital	-0.31%	-0.51%	-0.72%
210006 Harford Memorial Hospital	-0.45%	-0.63%	-0.81%
210016 Washington Adventist Hospital	-0.54%	-0.68%	-0.82%
210003 Prince Georges Hospital Center	-0.73%	-0.82%	-0.90%
210030 Chester River Hospital Center	-0.83%	-0.98%	-1.14%
210055 Laurel Regional Hospital	-0.73%	-0.95%	-1.17%
210051 Doctors Community Hospital	-1.02%	-1.26%	-1.49%

Note: Although this is not shown in this simulation, all parties agree that combined negative scaling for any hospital should be limited to the magnitude of the base update approved by the Commission (MB + Forecast error + Policy Adjustment + Slippage)

Additionally - there is agreement that the scaling should be revenue neutral and that any reduction in a given hospital's negative scaling be redistributed to all other negatively scaled hospitals to reduce the amount of their offset.

Staff Proposal Simulated

Eliminate QBR Scaling, 0.75% MHACs & 15% of Difference between ROC position and Peer Average

	MHACs @ 0.5 Scaling	QBR @ 0.5% Scaling	ROC @ 15% of Position vs Peer Avg.	Combined
210001 Washington County Hospital	-0.16%	0.01%	1.00%	0.85%
210002 University of Maryland Hospital	-0.41%	-0.01%	0.00%	-0.42%
210003 Prince Georges Hospital Center	-0.50%	-0.06%	-0.26%	-0.82%
210004 Holy Cross Hospital	0.05%	0.03%	0.22%	0.30%
210005 Frederick Memorial Hospital	0.21%	0.01%	0.96%	1.18%
210006 Harford Memorial Hospital	-0.11%	0.03%	-0.55%	-0.63%
210007 St. Joseph Medical Center	0.06%	0.02%	-0.32%	-0.24%
210008 Mercy Medical Center	0.31%	0.02%	0.43%	0.76%
210009 Johns Hopkins Hospital	-0.07%	0.01%	-0.46%	-0.52%
210010 Dorchester General Hospital	-0.13%	0.00%	1.88%	1.75%
210011 St. Agnes Hospital	0.07%	-0.02%	0.17%	0.22%
210012 Sinai Hospital	-0.14%	0.01%	-0.32%	-0.45%
210013 Bon Secours Hospital	0.12%	-0.08%	NA	0.04%
210015 Franklin Square Hospital Center	0.23%	0.02%	0.29%	0.54%
210016 Washington Adventist Hospital	-0.26%	-0.00%	-0.42%	-0.68%
210017 Garrett County Memorial Hospital	0.23%	-0.01%	1.44%	1.66%
210018 Montgomery General Hospital	0.09%	0.02%	-0.61%	-0.51%
210019 Peninsula Regional Medical Center	0.19%	-0.02%	0.00%	0.17%
210022 Suburban Hospital	0.08%	0.00%	-0.38%	-0.30%
210023 Anne Arundel Medical Center	-0.04%	-0.03%	0.81%	0.74%
210024 Union Memorial Hospital	0.21%	0.01%	-0.15%	0.07%
210025 Western MD (estimated)	0.11%	-0.03%	-0.18%	-0.11%
210028 St. Mary's Hospital	0.15%	0.02%	-0.24%	-0.07%
210029 Johns Hopkins Bayview Medical Cent	0.06%	0.00%	0.27%	0.33%
210030 Chester River Hospital Center	-0.50%	-0.03%	-0.45%	-0.98%
210032 Union of Cecil	-0.10%	0.02%	0.79%	0.71%
210033 Carroll Hospital Center	0.26%	0.02%	0.15%	0.43%
210034 Harbor Hospital Center	0.07%	0.01%	0.63%	0.71%
210035 Civista Medical Center	-0.42%	0.01%	0.30%	-0.12%
210037 Memorial Hospital at Easton	0.13%	-0.03%	1.35%	1.45%
210038 Maryland General Hospital	0.50%	-0.05%	0.60%	1.05%
210039 Calvert Memorial Hospital	0.21%	-0.01%	0.83%	1.03%
210040 Northwest Hospital Center	0.11%	-0.04%	-0.55%	-0.48%
210043 Baltimore Washington Medical Cente	0.07%	0.02%	0.10%	0.19%
210044 GBMC	0.20%	0.01%	-0.28%	-0.07%
210045 McCready Memorial Hospital	0.39%	-0.03%	NA	0.36%
210048 Howard County General Hospital	-0.24%	0.03%	-0.26%	-0.47%
210049 Upper Chesapeake Medical Center	-0.01%	0.02%	-0.15%	-0.14%
210051 Doctors Community Hospital	-0.50%	-0.04%	-0.72%	-1.26%
210054 Southern Maryland Hospital Center	0.36%	-0.01%	-0.47%	-0.12%
210055 Laurel Regional Hospital	-0.23%	-0.05%	-0.67%	-0.95%
210056 Good Samaritan Hospital	-0.01%	0.01%	0.15%	0.15%
210057 Shady Grove Adventist Hospital	-0.10%	0.01%	0.15%	0.06%
210058 James Lawrence Kernan Hospital	0.21%	0.00%	-0.43%	-0.22%
210060 Fort Washington	0.50%	-0.00%	0.02%	0.52%
210061 Atlantic General Hospital	0.11%	0.02%	-0.56%	-0.44%

MHA Proposal Simulated

0.5% QBR, 0.5% MHACs & 10% of Difference between ROC position and Peer Average

	MHACs @ 0.5% Scaling	QBR @ 0.5% Scaling	ROC @ 10% of Position vs Peer Avg.	**Combined**
210001 Washington County Hospital	-0.16%	0.01%	0.67%	0.52%
210002 University of Maryland Hospital	-0.41%	-0.01%	0.00%	-0.42%
210003 Prince Georges Hospital Center	-0.50%	-0.06%	-0.17%	-0.73%
210004 Holy Cross Hospital	0.05%	0.03%	0.15%	0.23%
210005 Frederick Memorial Hospital	0.21%	0.01%	0.64%	0.86%
210006 Harford Memorial Hospital	-0.11%	0.03%	-0.37%	-0.45%
210007 St. Joseph Medical Center	0.06%	0.02%	-0.22%	-0.14%
210008 Mercy Medical Center	0.31%	0.02%	0.29%	0.62%
210009 Johns Hopkins Hospital	-0.07%	0.01%	-0.31%	-0.37%
210010 Dorchester General Hospital	-0.13%	0.00%	1.25%	1.12%
210011 St. Agnes Hospital	0.07%	-0.02%	0.11%	0.16%
210012 Sinai Hospital	-0.14%	0.01%	-0.22%	-0.35%
210013 Bon Secours Hospital	0.12%	-0.08%	NA	0.04%
210015 Franklin Square Hospital Center	0.23%	0.02%	0.20%	0.45%
210016 Washington Adventist Hospital	-0.26%	-0.00%	-0.28%	-0.54%
210017 Garrett County Memorial Hospital	0.23%	-0.01%	0.96%	1.18%
210018 Montgomery General Hospital	0.09%	0.02%	-0.41%	-0.31%
210019 Peninsula Regional Medical Center	0.19%	-0.02%	0.00%	0.17%
210022 Suburban Hospital	0.08%	0.00%	-0.25%	-0.17%
210023 Anne Arundel Medical Center	-0.04%	-0.03%	0.54%	0.47%
210024 Union Memorial Hospital	0.21%	0.01%	-0.10%	0.12%
210027 Western MD (estimated)	0.11%	-0.03%	-0.12%	-0.05%
210028 St. Mary's Hospital	0.15%	0.02%	-0.16%	0.01%
210029 Johns Hopkins Bayview Medical Center	0.06%	0.00%	0.18%	0.24%
210030 Chester River Hospital Center	-0.50%	-0.03%	-0.30%	-0.83%
210032 Union of Cecil	-0.10%	0.02%	0.53%	0.45%
210033 Carroll Hospital Center	0.26%	0.02%	0.10%	0.38%
210034 Harbor Hospital Center	0.07%	0.01%	0.42%	0.50%
210035 Civista Medical Center	-0.42%	0.01%	0.20%	-0.22%
210037 Memorial Hospital at Easton	0.13%	-0.03%	0.90%	1.00%
210038 Maryland General Hospital	0.50%	-0.05%	0.40%	0.85%
210039 Calvert Memorial Hospital	0.21%	-0.01%	0.56%	0.76%
210040 Northwest Hospital Center	0.11%	-0.04%	-0.37%	-0.30%
210043 Baltimore Washington Medical Center	0.07%	0.02%	0.06%	0.15%
210044 GBMC	0.20%	0.01%	-0.19%	0.02%
210045 McCready Memorial Hospital	0.39%	-0.03%	NA	0.36%
210048 Howard County General Hospital	-0.24%	0.03%	-0.17%	-0.38%
210049 Upper Chesapeake Medical Center	-0.01%	0.02%	-0.10%	-0.09%
210051 Doctors Community Hospital	-0.50%	-0.04%	-0.48%	-1.02%
210054 Southern Maryland Hospital Center	0.36%	-0.01%	-0.31%	0.04%
210055 Laurel Regional Hospital	-0.23%	-0.05%	-0.45%	-0.73%
210056 Good Samaritan Hospital	-0.01%	0.01%	0.10%	0.10%
210057 Shady Grove Adventist Hospital	-0.10%	0.01%	0.10%	0.01%
210058 James Lawrence Kernan Hospital	0.21%	0.00%	-0.28%	-0.07%
210060 Fort Washington	0.50%	-0.00%	0.01%	0.51%
210061 Atlantic General Hospital	0.11%	0.02%	-0.38%	-0.26%

Payer Proposal Simulated

0.5% QBR, 0.5% MHACs & 20% of Difference between ROC position and Peer Average

	MHACs @ 0.5% Scaling	QBR @ 0.5% Scaling	ROC @ 20% of Position vs Peer Avg.	Combined
210001 Washington County Hospital	-0.16%	0.013%	1.33%	1.18%
210002 University of Maryland Hospital	-0.41%	-0.010%	0.00%	-0.42%
210003 Prince Georges Hospital Center	-0.50%	-0.060%	-0.34%	-0.90%
210004 Holy Cross Hospital	0.05%	0.025%	0.29%	0.37%
210005 Frederick Memorial Hospital	0.21%	0.013%	1.28%	1.50%
210006 Harford Memorial Hospital	-0.11%	0.034%	-0.73%	-0.81%
210007 St. Joseph Medical Center	0.06%	0.020%	-0.43%	-0.35%
210008 Mercy Medical Center	0.31%	0.024%	0.57%	0.90%
210009 Johns Hopkins Hospital	-0.07%	0.008%	-0.62%	-0.68%
210010 Dorchester General Hospital	-0.13%	0.000%	2.51%	2.38%
210011 St. Agnes Hospital	0.07%	-0.020%	0.22%	0.27%
210012 Sinai Hospital	-0.14%	0.008%	-0.43%	-0.56%
210013 Bon Secours Hospital	0.12%	-0.082%	NA	0.04%
210015 Franklin Square Hospital Center	0.23%	0.018%	0.39%	0.64%
210016 Washington Adventist Hospital	-0.26%	-0.001%	-0.56%	-0.82%
210017 Garrett County Memorial Hospital	0.23%	-0.012%	1.92%	2.14%
210018 Montgomery General Hospital	0.09%	0.015%	-0.82%	-0.72%
210019 Peninsula Regional Medical Center	0.19%	-0.024%	-0.01%	0.16%
210022 Suburban Hospital	0.08%	0.002%	-0.51%	-0.43%
210023 Anne Arundel Medical Center	-0.04%	-0.027%	1.09%	1.02%
210024 Union Memorial Hospital	0.21%	0.010%	-0.19%	0.03%
210027 Western MD (estimated)	0.11%	-0.035%	-0.23%	-0.16%
210028 St. Mary's Hospital	0.15%	0.020%	-0.32%	-0.15%
210029 Johns Hopkins Bayview Medical Cent	0.06%	0.000%	0.36%	0.42%
210030 Chester River Hospital Center	-0.50%	-0.025%	-0.61%	-1.14%
210032 Union of Cecil	-0.10%	0.018%	1.05%	0.97%
210033 Carroll Hospital Center	0.26%	0.018%	0.20%	0.48%
210034 Harbor Hospital Center	0.07%	0.014%	0.85%	0.93%
210035 Civista Medical Center	-0.42%	0.005%	0.39%	-0.03%
210037 Memorial Hospital at Easton	0.13%	-0.032%	1.80%	1.90%
210038 Maryland General Hospital	0.50%	-0.048%	0.80%	1.25%
210039 Calvert Memorial Hospital	0.21%	-0.013%	1.11%	1.31%
210040 Northwest Hospital Center	0.11%	-0.037%	-0.73%	-0.66%
210043 Baltimore Washington Medical Cente	0.07%	0.024%	0.13%	0.22%
210044 GBMC	0.20%	0.014%	-0.38%	-0.17%
210045 McCready Memorial Hospital	0.39%	-0.027%	NA	0.36%
210048 Howard County General Hospital	-0.24%	0.026%	-0.35%	-0.56%
210049 Upper Chesapeake Medical Center	-0.01%	0.024%	-0.20%	-0.19%
210051 Doctors Community Hospital	-0.50%	-0.040%	-0.0095	-1.49%
210054 Southern Maryland Hospital Center	0.36%	-0.007%	-0.63%	-0.28%
210055 Laurel Regional Hospital	-0.23%	-0.049%	-0.89%	-1.17%
210056 Good Samaritan Hospital	-0.01%	0.010%	0.19%	0.19%
210057 Shady Grove Adventist Hospital	-0.10%	0.006%	0.20%	0.11%
210058 James Lawrence Kernan Hospital	0.21%	0.000%	-0.57%	-0.36%
210060 Fort Washington	0.50%	-0.004%	0.02%	0.52%
210061 Atlantic General Hospital	0.11%	0.015%	-0.0075	-0.63%

Appendix II – FY 2011 Industry Financial Simulations (for each Update Option) based on Different assumptions regarding Hospital Productivity Improvements and Ability to reduce Physician Losses

Projected System Operating Profitability (regulated and total operating profits) of Each Update Option under different Scenarios

Assumptions:

	Admissions	O/P Volume	Total EIPAs
1 FY 2009	702,235	397,852	1,100,087
2 FY 2010	695,987	420,911	1,116,898
3 FY 2011	702,235	445,306	1,147,541

4 Estimated Regulated Revenue Per EIPA 2010	$9,930
5 Estimated Regluated Expense Per EIPA 2010	$9,346
6 Cost Inflation 2011	2.67%

	Reg. Revenue	Reg. Expense	Profits	Margin	Unreg Profit/Loss	Margin	Total Margin
Base FY 2010 Assumped Financials (based on 10 mo YTD data)	$11,394,836,379	$10,724,646,644	$670,189,734	5.88%	($417,239,037)	-36.82%	2.02%

Forecast Under different Assuptions of Productivity and Physician Loss

Scenario 1: 0% Productivity Improvement and 0% reduction in Physician Losses

			No Erosion Update Option 1	Payer Update Option 2	Target 6% Update Option 3	Peg Medicaid Update Option 4	MHA Update Option 5
7 Markup Change (UC)			0.44%	0.44%	0.44%	0.44%	0.44%
8 ODS CMI impact ($29 million)			0.21%	0.21%	0.21%	0.21%	0.21%
9 Medicaid Assessment			-0.07%	-0.07%	-0.07%	-0.07%	-0.07%
10 Update			0.77%	1.58%	1.91%	2.05%	2.97%
11 Total Update to Rates			1.35%	2.16%	2.49%	2.63%	3.55%
12 Base Revenue per EIPA	$9,930		$10,064	$10,144	$10,177	$10,191	$10,282
13 EIPAs			1,147,541	1,147,541	1,147,541	1,147,541	1,147,541
	FY 2010						
14 Total Net Operating Revenue	$12,528,167,206		$12,682,081,903	$12,774,380,078	$12,811,983,038	$12,827,935,809	$12,932,768,304
15 Total Net Operating Expense	$12,275,216,509		$12,561,564,574	$12,561,564,574	$12,561,564,574	$12,561,564,574	$12,561,564,574
16 Total Op Profit	$252,950,697		$120,517,329	$212,815,504	$250,418,464	$266,371,235	$371,203,729
	2.02%						
17 Regulated Revenues	$11,394,836,379	Productivity	$11,548,751,076	$11,641,049,251	$11,678,652,211	$11,694,604,982	$11,799,437,476
18 Regulated Expense	$10,724,646,644	0.00%	$11,010,994,710	$11,010,994,710	$11,010,994,710	$11,010,994,710	$11,010,994,710
19 Total Regulated Op Profit	$670,189,734		$537,756,366	$630,054,541	$667,657,501	$683,610,272	$788,442,767
20 **Regulated Operating Profit Margin**	**5.88%**		**4.66%**	**5.41%**	**5.72%**	**5.85%**	**6.68%**
21 Unregulated Revneue Other	$809,920,909		$809,920,909	$809,920,909	$809,920,909	$809,920,909	$809,920,909
22 Unregulated Expense Other	$907,567,934		$907,567,934	$907,567,934	$907,567,934	$907,567,934	$907,567,934
	($97,647,024)		($97,647,024)	($97,647,024)	($97,647,024)	($97,647,024)	($97,647,024)
	-12.06%		-12.06%	-12.06%	-12.06%	-12.06%	-12.06%
23 Unregulated Revenue Part B	$323,409,918	Physician Losses	$323,409,918	$323,409,918	$323,409,918	$323,409,918	$323,409,918
24 Unregulated Expense Part B	$643,001,931	100.00%	$643,001,931	$643,001,931	$643,001,931	$643,001,931	$643,001,931
	(319,592,013)	of Prior Year	(319,592,013)	(319,592,013)	(319,592,013)	(319,592,013)	(319,592,013)
	-98.82%		-98.82%	-98.82%	-98.82%	-98.82%	-98.82%
25 Unregulated Revenue	1,133,330,828		1,133,330,828	1,133,330,828	1,133,330,828	1,133,330,828	1,133,330,828
26 Unregulated Expense	1,550,569,865		1,550,569,865	1,550,569,865	1,550,569,865	1,550,569,865	1,550,569,865
	(417,239,037)		(417,239,037)	(417,239,037)	(417,239,037)	(417,239,037)	(417,239,037)
	-36.82%		-36.82%	-36.82%	-36.82%	-36.82%	-36.82%
27 Recast Operating Profit							
28 Revenues			$12,682,081,903	$12,774,380,078	$12,811,983,038	$12,827,935,809	$12,932,768,304
29 Expenses			$12,561,564,574	$12,561,564,574	$12,561,564,574	$12,561,564,574	$12,561,564,574
30 **Total Operating Profit**			**120,517,329**	**212,815,504**	**250,418,464**	**266,371,235**	**371,203,729**
31 **Operating Margin**			**0.95%**	**1.67%**	**1.95%**	**2.08%**	**2.87%**

Projected System Operating Profitability (regulated and total operating profits) of Each Update Option under different Scenarios

Assumptions:

	Admissions	O/P Volume	Total EIPAs
1 FY 2009	702,235	397,852	1,100,087
2 FY 2010	695,987	420,911	1,116,898
3 FY 2011	702,235	445,306	1,147,541

4 Estimated Regulated Revenue Per EIPA 2010	$9,930
5 Estimated Regluated Expense Per EIPA 2010	$9,346
6 Cost Inflation 2011	2.67%

	Reg. Revenue	Reg. Expense	Profits	Margin	Unreg Profit/Loss	Margin	Total Margin
Base FY 2010 Assumped Financials (based on 10 mo YTD data)	$11,394,836,379	$10,724,646,644	$670,189,734	5.88%	($417,239,037)	-36.82%	2.02%

Forecast Under different Assuptions of Productivity and Physician Loss

Scenario 2: 0.5% Productivity Improvement and 5% reduction in Physician Losses

			No Erosion Update Option 1	Payer Update Option 2	Target 6% Update Option 3	Peg Medicaid Update Option 4	MHA Update Option 5
7 Markup Change (UC)			0.44%	0.44%	0.44%	0.44%	0.44%
8 ODS CMI impact ($29 million)			0.21%	0.21%	0.21%	0.21%	0.21%
9 Medicaid Assessment			-0.07%	-0.07%	-0.07%	-0.07%	-0.07%
10 Update			0.77%	1.58%	1.91%	2.05%	2.97%
11 Total Update to Rates			1.35%	2.16%	2.49%	2.63%	3.55%
12 Base Revenue per EIPA	$9,930		$10,064	$10,144	$10,177	$10,191	$10,282
13 EIPAs			1,147,541	1,147,541	1,147,541	1,147,541	1,147,541
	FY 2010						
14 Total Net Operating Revenue	$12,528,167,206		$12,682,081,903	$12,774,380,078	$12,811,983,038	$12,827,935,809	$12,932,768,304
15 Total Net Operating Expense	$12,275,216,509		$12,475,791,245	$12,475,791,245	$12,475,791,245	$12,475,791,245	$12,475,791,245
16 Total Op Profit	$252,950,697		$206,290,659	$298,588,833	$336,191,793	$352,144,564	$456,977,059
	2.02%						
17 Regulated Revenues	$11,394,836,379	Productivity	$11,548,751,076	$11,641,049,251	$11,678,652,211	$11,694,604,982	$11,799,437,476
18 Regulated Expense	$10,724,646,644	**0.50%**	$10,957,371,476	$10,957,371,476	$10,957,371,476	$10,957,371,476	$10,957,371,476
19 Total Regulated Op Profit	$670,189,734		$591,379,600	$683,677,774	$721,280,734	$737,233,505	$842,066,000
20 **Regulated Operating Profit Margin**	**5.88%**		**5.12%**	**5.87%**	**6.18%**	**6.30%**	**7.14%**
21 Unregulated Revneue Other	$809,920,909		$809,920,909	$809,920,909	$809,920,909	$809,920,909	$809,920,909
22 Unregulated Expense Other	$907,567,934		$907,567,934	$907,567,934	$907,567,934	$907,567,934	$907,567,934
	($97,647,024)		($97,647,024)	($97,647,024)	($97,647,024)	($97,647,024)	($97,647,024)
	-12.06%		-12.06%	-12.06%	-12.06%	-12.06%	-12.06%
23 Unregulated Revenue Part B	$323,409,918	Physician Losses	$323,409,918	$323,409,918	$323,409,918	$323,409,918	$323,409,918
24 Unregulated Expense Part B	$643,001,931	**95.00%**	$610,851,835	$610,851,835	$610,851,835	$610,851,835	$610,851,835
	(319,592,013)	of Prior Year	(287,441,917)	(287,441,917)	(287,441,917)	(287,441,917)	(287,441,917)
	-98.82%		-88.88%	-88.88%	-88.88%	-88.88%	-88.88%
25 Unregulated Revenue	1,133,330,828		1,133,330,828	1,133,330,828	1,133,330,828	1,133,330,828	1,133,330,828
26 Unregulated Expense	1,550,569,865		1,518,419,768	1,518,419,768	1,518,419,768	1,518,419,768	1,518,419,768
	(417,239,037)		(385,088,941)	(385,088,941)	(385,088,941)	(385,088,941)	(385,088,941)
	-36.82%		-33.98%	-33.98%	-33.98%	-33.98%	-33.98%
27 Recast Operating Profit							
28 Revenues			$12,682,081,903	$12,774,380,078	$12,811,983,038	$12,827,935,809	$12,932,768,304
29 Expenses			$12,475,791,245	$12,475,791,245	$12,475,791,245	$12,475,791,245	$12,475,791,245
30 **Total Operating Profit**			**206,290,659**	**298,588,833**	**336,191,793**	**352,144,564**	**456,977,059**
31 **Operating Margin**			**1.63%**	**2.34%**	**2.62%**	**2.75%**	**3.53%**

Projected System Operating Profitability (regulated and total operating profits) of Each Update Option under different Scenarios

Assumptions:

	Admissions	O/P Volume	Total EIPAs
1 FY 2009	702,235	397,852	1,100,087
2 FY 2010	695,987	420,911	1,116,898
3 FY 2011	702,235	445,306	1,147,541

4 Estimated Regulated Revenue Per EIPA 2010	$9,930
5 Estimated Regluated Expense Per EIPA 2010	$9,346
6 Cost Inflation 2011	2.67%

	Reg. Revenue	Reg. Expense	Profits	Margin	Unreg Profit/Loss	Margin	Total Margin
Base FY 2010 Assumped Financials (based on 10 mo YTD data)	$11,394,836,379	$10,724,646,644	$670,189,734	5.88%	($417,239,037)	-36.82%	2.02%

Forecast Under different Assuptions of Productivity and Physician Loss

Scenario 3: 1.0% Productivity Improvement and 10% reduction in Physician Losses

			No Erosion Update Option 1	Payer Update Option 2	Target 6% Update Option 3	Peg Medicaid Update Option 4	MHA Update Option 5
7 Markup Change (UC)			0.44%	0.44%	0.44%	0.44%	0.44%
8 ODS CMI impact ($29 million)			0.21%	0.21%	0.21%	0.21%	0.21%
9 Medicaid Assessment			-0.07%	-0.07%	-0.07%	-0.07%	-0.07%
10 Update			0.77%	1.58%	1.91%	2.05%	2.97%
11 Total Update to Rates			1.35%	2.16%	2.49%	2.63%	3.55%
12 Base Revenue per EIPA	$9,930		$10,064	$10,144	$10,177	$10,191	$10,282
13 EIPAs			1,147,541	1,147,541	1,147,541	1,147,541	1,147,541
	FY 2010						
14 Total Net Operating Revenue	$12,528,167,206		$12,682,081,903	$12,774,380,078	$12,811,983,038	$12,827,935,809	$12,932,768,304
15 Total Net Operating Expense	$12,275,216,509		$12,390,017,915	$12,390,017,915	$12,390,017,915	$12,390,017,915	$12,390,017,915
16 Total Op Profit	$252,950,697		$292,063,989	$384,362,163	$421,965,123	$437,917,894	$542,750,389
	2.02%						
17 Regulated Revenues	$11,394,836,379	Productivity	$11,548,751,076	$11,641,049,251	$11,678,652,211	$11,694,604,982	$11,799,437,476
18 Regulated Expense	$10,724,646,644	1.00%	$10,903,748,243	$10,903,748,243	$10,903,748,243	$10,903,748,243	$10,903,748,243
19 Total Regulated Op Profit	$670,189,734		$645,002,833	$737,301,007	$774,903,967	$790,856,738	$895,689,233
20 **Regulated Operating Profit Margin**	**5.88%**		**5.59%**	**6.33%**	**6.64%**	**6.76%**	**7.59%**
21 Unregulated Revneue Other	$809,920,909		$809,920,909	$809,920,909	$809,920,909	$809,920,909	$809,920,909
22 Unregulated Expense Other	$907,567,934		$907,567,934	$907,567,934	$907,567,934	$907,567,934	$907,567,934
	($97,647,024)		($97,647,024)	($97,647,024)	($97,647,024)	($97,647,024)	($97,647,024)
	-12.06%		-12.06%	-12.06%	-12.06%	-12.06%	-12.06%
23 Unregulated Revenue Part B	$323,409,918	Physician Losses	$323,409,918	$323,409,918	$323,409,918	$323,409,918	$323,409,918
24 Unregulated Expense Part B	$643,001,931	90.00%	$578,701,738	$578,701,738	$578,701,738	$578,701,738	$578,701,738
	(319,592,013)	of Prior Year	(255,291,820)	(255,291,820)	(255,291,820)	(255,291,820)	(255,291,820)
	-98.82%		-78.94%	-78.94%	-78.94%	-78.94%	-78.94%
25 Unregulated Revenue	1,133,330,828		1,133,330,828	1,133,330,828	1,133,330,828	1,133,330,828	1,133,330,828
26 Unregulated Expense	1,550,569,865		1,486,269,672	1,486,269,672	1,486,269,672	1,486,269,672	1,486,269,672
	(417,239,037)		(352,938,844)	(352,938,844)	(352,938,844)	(352,938,844)	(352,938,844)
	-36.82%		-31.14%	-31.14%	-31.14%	-31.14%	-31.14%
27 Recast Operating Profit							
28 Revenues			$12,682,081,903	$12,774,380,078	$12,811,983,038	$12,827,935,809	$12,932,768,304
29 Expenses			$12,390,017,915	$12,390,017,915	$12,390,017,915	$12,390,017,915	$12,390,017,915
30 **Total Operating Profit**			**292,063,989**	**384,362,163**	**421,965,123**	**437,917,894**	**542,750,389**
31 **Operating Margin**			**2.30%**	**3.01%**	**3.29%**	**3.41%**	**4.20%**

Results of Financial Simulation under Different Productivity Scenarios

	No Erosion Update Option 1	Payer Update Option 2	Target 6% Update Option 3	Peg Medicaid Update Option 4	MHA Update Option 5
Scenario 1:					
No Productivity/No Reduction in Unregulated Loss					
Regulated Operating Margins	4.66%	5.41%	5.72%	5.85%	6.68%
Total Operating Margins	0.95%	1.67%	1.95%	2.08%	2.87%
Scenario 2:					
0.5% Productivity Gain/5% Reduction in Unregulated Loss					
Regulated Operating Margins	5.12%	5.87%	6.18%	6.30%	7.14%
Total Operating Margins	1.63%	2.34%	2.62%	2.75%	3.53%
Scenario 3:					
1.0% Productivity/10% Reduction in Unregulated Loss					
Regulated Operating Margins	5.59%	6.33%	6.64%	6.76%	7.59%
Total Operating Margins	2.30%	3.01%	3.29%	3.41%	4.20%

Appendix III – Detailed Impact Analysis – Extrapolation of Each Update Option relative to Projected US Medicare and All-Payer Growth Rates

Exhibit 3a: Updated Medicare Cushion and NOR, NPR and Cost per EIPA Position

Line #	MHA Update	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
1	US NPR Growth		3.03%	3.82%	3.96%	3.96%	3.96%	3.96%	3.96%	3.96%	3.96%
2	MD Update = MB +/-		0.68%	0.65%	0.65%	0.65%	0.65%	0.65%	0.65%	0.65%	0.65%
	Maryland Update										
3	MB		2.29%	2.90%	3.00%	3.00%	3.00%	3.00%	3.00%	3.00%	3.00%
4	Error		0.38%	0.38%	0.38%	0.38%	0.38%	0.38%	0.38%	0.38%	0.38%
5	Subtot		2.67%	3.28%	3.38%	3.38%	3.38%	3.38%	3.38%	3.38%	3.38%
6	Policy		-0.48%	-0.48%	-0.48%	-0.48%	-0.48%	-0.48%	-0.48%	-0.48%	-0.48%
7	Subtot		2.19%	2.80%	2.90%	2.90%	2.90%	2.90%	2.90%	2.90%	2.90%
8	Slippage		0.03%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
9	Casemix		0.98%	0.98%	0.98%	0.98%	0.98%	0.98%	0.98%	0.98%	0.98%
10	Subtot		3.20%	3.78%	3.88%	3.88%	3.88%	3.88%	3.88%	3.88%	3.88%
11	Volume		-0.23%	-0.23%	-0.23%	-0.23%	-0.23%	-0.23%	-0.23%	-0.23%	-0.23%
12	**Total Update**		**2.97%**	**3.55%**	**3.65%**	**3.65%**	**3.65%**	**3.65%**	**3.65%**	**3.65%**	**3.65%**
13	**Inpatient Update**		**2.74%**	**3.33%**	**3.43%**	**3.43%**	**3.43%**	**3.43%**	**3.43%**	**3.43%**	**3.43%**
		2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
	Medicare Update										
14	MB		2.30%	2.90%	3.00%	3.00%	3.00%	3.00%	3.00%	3.00%	3.00%
15	Outlier Pmts		0.40%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
16	DSH		0.00%	0.00%	0.00%	0.00%	-0.47%	-0.47%	-0.47%	-0.47%	0.00%
17	Reform		-0.25%	-0.25%	-0.10%	-0.10%	-0.30%	-0.20%	-0.20%	-0.75%	-0.75%
18	Productivity		0.00%	0.00%	-1.30%	-1.30%	-1.30%	-1.30%	-1.30%	-1.30%	-1.30%
19	Medicare Commission		0.00%	0.00%	0.00%	0.00%	-0.50%	-0.50%	-0.25%	-0.25%	-0.50%
20	Coding Retro		-1.93%	0.00%	0.00%	1.93%	0.00%	0.00%	0.00%	0.00%	0.00%
21	Coding Prospective		0.00%	-1.50%	-1.00%	-3.00%	0.00%	0.00%	0.00%	0.00%	0.00%
22	Case mix		1.00%	0.50%	0.50%	0.50%	0.50%	0.50%	0.50%	0.50%	0.50%
	Total Medicare Update		**1.52%**	**1.65%**	**1.10%**	**1.03%**	**0.93%**	**1.03%**	**1.28%**	**0.73%**	**0.95%**
		Unadjusted									
23	Waiver Cushion	9.46%	13.88%	11.28%	9.34%	6.77%	4.77%	2.03%	1.54%	1.29%	0.00%
24	MSP & MA adj.	4.70%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
25	Medicare Slower Growth		0.26%	0.31%	0.32%	0.32%	0.32%	0.32%	0.32%	0.32%	0.32%
26	ODS adj.	-0.28%	-0.56%	-0.56%	-0.56%	-0.56%	-0.56%	0.00%	0.00%	0.00%	0.00%
27	UC Markup		-0.44%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
28	Assessment		-0.64%	0.00%	0.00%	**0.64%**	0.00%	0.00%	0.00%	0.00%	0.00%
29	MHIP		0.00%	0.00%	0.00%	0.00%	0.00%	0.50%	0.50%	0.00%	0.00%
30	UC Reduction		0.00%	0.00%	0.00%	0.00%	0.00%	1.09%	1.09%	1.09%	1.09%
31	**Update Erosion vs. Medicare**		**-1.22%**	**-1.68%**	**-2.33%**	**-2.40%**	**-2.50%**	**-2.40%**	**-2.15%**	**-2.70%**	**-2.48%**
32	**Total Waiver Erosion**		**-2.60%**	**-1.93%**	**-2.57%**	**-2.00%**	**-2.74%**	**-0.49%**	**-0.24%**	**-1.29%**	**-1.07%**
33	**Waiver Cushion**	**13.88%**	**11.28%**	**9.34%**	**6.77%**	**4.77%**	**2.03%**	**1.54%**	**1.29%**	**0.00%**	**-1.07%**
34	NOR/EIPA	-1.21%	-1.27%	-1.53%	-1.83%	-2.12%	-2.41%	-2.70%	-2.99%	-3.28%	-3.57%
35	NPR/EIPA	0.38%	0.32%	0.05%	-0.26%	-0.56%	-0.86%	-1.16%	-1.46%	-1.76%	-2.06%
36	**Cost/EIPA**	-0.11%	-0.11%	-0.29%	-0.50%	-0.71%	**-0.92%**	-1.13%	-1.34%	-1.55%	-1.55%

Summary of Results: MHA Proposal

		2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Avg Chg.
37	Outperform US (positive=outperform)		-0.06%	-0.27%	-0.31%	-0.31%	-0.31%	-0.31%	-0.31%	-0.31%	-0.31%	-0.27%
38	Waiver Erosion		-2.60%	-1.93%	-2.57%	-2.00%	-2.74%	-0.49%	-0.24%	-1.29%	-1.07%	-1.66%
39	MD Net Patient Revenue	$11,969	$12,525	$13,179	$13,880	$14,618	$15,396	$16,215	$17,077	$17,986	$18,943	
40	MD Total Operating Cost (Mill $)	$12,199	$12,765	$13,431	$14,146	$14,898	$15,691	$16,525	$17,405	$18,330	$19,306	5 yr saving
41	Cost Savings vs US Growth (Mill $) (negative numbers = dissavings)		$8	$43	$86	$134	$188	$246	$310	$381	$458	$459 9 yr saving
42	Position vs. US Cost/EIPA						-0.92%					$1,855
43	Medicaid Share	17.50%	18.00%	18.50%	19.00%	19.50%	20.00%	20.00%	20.00%	20.00%	20.00%	
44	Medicaid Pmts	$2,095	$2,254	$2,438	$2,637	$2,851	$3,079	$3,243	$3,415	$3,597	$3,789	5 yr saving
45	Savings vs. US Growth	$0	$1	$8	$16	$26	$37	$48	$61	$75	$90	$88
46	**Waiver Cushion**	**13.88%**	**11.28%**	**9.34%**	**6.77%**	**4.77%**	**2.03%**	**1.54%**	**1.29%**	**0.00%**	**-1.07%**	
47	**Cost per EIPA Position vs US**	**-0.11%**	**-0.11%**	**-0.29%**	**-0.50%**	**-0.71%**	**-0.92%**	**-1.13%**	**-1.34%**	**-1.55%**	**-1.55%**	

Exhibit 3b: Updated Medicare Cushion and NOR, NPR and Cost per EIPA Position

Line #	Payer Update	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
1	US NPR Growth		3.03%	3.82%	3.96%	3.96%	3.96%	3.96%	3.96%	3.96%	3.96%
2	MD Update = MB +/-		-0.71%	-0.90%	-0.94%	-0.94%	-0.94%	-0.94%	-0.94%	-0.94%	-0.94%
	Maryland Update										
3	MB		2.29%	2.90%	3.00%	3.00%	3.00%	3.00%	3.00%	3.00%	3.00%
4	Error		0.38%	0.38%	0.38%	0.38%	0.38%	0.38%	0.38%	0.38%	0.38%
5	Subtot		2.67%	3.28%	3.38%	3.38%	3.38%	3.38%	3.38%	3.38%	3.38%
6	Policy		-1.87%	-2.03%	-2.07%	-2.07%	-2.07%	-2.07%	-2.07%	-2.07%	-2.07%
7	Subtot		0.80%	1.25%	1.31%	1.31%	1.31%	1.31%	1.31%	1.31%	1.31%
8	Slippage		0.03%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
9	Casemix		0.98%	0.98%	0.98%	0.98%	0.98%	0.98%	0.98%	0.98%	0.98%
10	Subtot		1.81%	2.23%	2.29%	2.29%	2.29%	2.29%	2.29%	2.29%	2.29%
11	Volume		-0.23%	-0.23%	-0.23%	-0.23%	-0.23%	-0.23%	-0.23%	-0.23%	-0.23%
12	**Total Update**		**1.58%**	**2.00%**	**2.06%**	**2.06%**	**2.06%**	**2.06%**	**2.06%**	**2.06%**	**2.06%**
13	**Inpatient Update**		**1.35%**	**1.78%**	**1.84%**	**1.84%**	**1.84%**	**1.84%**	**1.84%**	**1.84%**	**1.84%**
		2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
	Medicare Update										
14	MB		2.30%	2.90%	3.00%	3.00%	3.00%	3.00%	3.00%	3.00%	3.00%
15	Outlier		0.40%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
16	DSH		0.00%	0.00%	0.00%	0.00%	-0.47%	-0.47%	-0.47%	-0.47%	0.00%
17	Reform		-0.25%	-0.25%	-0.10%	-0.10%	-0.30%	-0.20%	-0.20%	-0.75%	-0.75%
18	Productivity		0.00%	0.00%	-1.30%	-1.30%	-1.30%	-1.30%	-1.30%	-1.30%	-1.30%
19	Medicare Comm.		0.00%	0.00%	0.00%	0.00%	-0.50%	-0.50%	-0.25%	-0.25%	-0.50%
20	Coding Retro		-1.93%	0.00%	0.00%	1.93%	0.00%	0.00%	0.00%	0.00%	0.00%
21	Coding Prosp		0.00%	-1.50%	-1.00%	-3.00%	0.00%	0.00%	0.00%	0.00%	0.00%
22	Case mix		1.00%	0.50%	0.50%	0.50%	0.50%	0.50%	0.50%	0.50%	0.50%
	Total Medicare Update		**1.52%**	**1.65%**	**1.10%**	**1.03%**	**0.93%**	**1.03%**	**1.28%**	**0.73%**	**0.95%**
		Unadjusted									
23	Waiver Cushion	9.46%	13.88%	12.54%	12.03%	10.91%	10.35%	9.06%	10.02%	11.22%	11.38%
24	MSP & MA adj.	4.70%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
25	Medicare Slower Growth		0.14%	0.17%	0.18%	0.18%	0.18%	0.18%	0.18%	0.18%	0.18%
26	ODS adj.	-0.28%	-0.56%	-0.56%	-0.56%	-0.56%	-0.56%	0.00%	0.00%	0.00%	0.00%
27	UC Markup		-0.44%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
28	Assessment		-0.64%	0.00%	0.00%	0.64%	0.00%	0.00%	0.00%	0.00%	0.00%
29	MHIP		0.00%	0.00%	0.00%	0.00%	0.00%	0.50%	0.50%	0.00%	0.00%
30	UC Reduction		0.00%	0.00%	0.00%	0.00%	0.00%	1.09%	1.09%	1.09%	1.09%
31	**Update Erosion vs. Medicare**		**0.17%**	**-0.13%**	**-0.74%**	**-0.81%**	**-0.91%**	**-0.81%**	**-0.56%**	**-1.11%**	**-0.89%**
32	Total Waiver Erosion		-1.33%	-0.51%	-1.12%	-0.55%	-1.29%	0.96%	1.21%	0.16%	0.38%
33	**Waiver Cushion**	**13.88%**	**12.54%**	**12.03%**	**10.91%**	**10.35%**	**9.06%**	**10.02%**	**11.22%**	**11.38%**	**11.76%**
34	NOR/EIPA	-1.21%	-2.61%	-4.33%	-6.08%	-7.80%	-9.49%	-11.14%	-12.77%	-14.36%	-15.93%
35	NPR/EIPA	0.38%	-1.04%	-2.79%	-4.57%	-6.31%	-8.03%	-9.71%	-11.36%	-12.98%	-14.57%
36	**Cost/EIPA**	-0.11%	-1.40%	-3.00%	-4.62%	-6.21%	**-7.78%**	-9.32%	-10.84%	-12.33%	-12.33%

Summary of Results: Payer Proposal

Line		2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Avg Chg.
37	Outperform US (positive=outperform)		-1.45%	-1.83%	-1.89%	-1.89%	-1.89%	-1.89%	-1.89%	-1.89%	-1.89%	-1.84%
38	Waiver Erosion		-1.33%	-0.51%	-1.12%	-0.55%	-1.29%	0.96%	1.21%	0.16%	0.38%	-0.24%
39	Net Patient Revenue	$11,969	$12,358	$12,811	$13,290	$13,786	$14,301	$14,835	$15,389	$15,963	$16,559	
40	Total Operating Cost (Mill $)	$12,199	$12,595	$13,057	$13,544	$14,050	$14,575	$15,119	$15,684	$16,269	$16,877	5 yr saving
41	Cost Savings vs US Growth (Mill $) (negative numbers = dissavings)		$177	$417	$688	$982	$1,303	$1,652	$2,031	$2,442	$2,887	$3,568
												9 yr saving
42	Position vs US Cost/EIPA						-7.78%					$12,581
43	Medicaid Share	17.50%	18.00%	18.50%	19.00%	19.50%	20.00%	20.00%	20.00%	20.00%	20.00%	
44	Medicaid Pmts	$2,095	$2,225	$2,370	$2,525	$2,688	$2,860	$2,967	$3,078	$3,193	$3,312	5 yr saving
45	Savings vs. US Growth	$0	$31	$76	$128	$188	$256	$324	$399	$479	$567	$679
46	**Waiver Cushion**	**13.88%**	**12.54%**	**12.03%**	**10.91%**	**10.35%**	**9.06%**	**10.02%**	**11.22%**	**11.38%**	**11.76%**	
47	**Cost per EIPA Position vs US**	**-0.11%**	**-1.40%**	**-3.00%**	**-4.62%**	**-6.21%**	**-7.78%**	**-9.32%**	**-10.84%**	**-12.33%**	**-12.33%**	

Exhibit 3c: Updated Medicare Cushion and NOR, NPR and Cost per EIPA Position

Medicaid (DBM budgeted) Update

Line #	Peg Medicaid Update	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
1	US NPR Growth (Staff)		3.03%	3.82%	3.96%	3.96%	3.96%	3.96%	3.96%	3.96%	3.96%
2	MD Update = MB +/-		-0.24%	-0.31%	-0.32%	-0.32%	-0.32%	-0.32%	-0.32%	-0.32%	-0.32%
	Maryland Update										
3	MB		2.29%	2.90%	3.00%	3.00%	3.00%	3.00%	3.00%	3.00%	3.00%
4	Error		0.38%	0.38%	0.38%	0.38%	0.38%	0.38%	0.38%	0.38%	0.38%
5	Subtot		2.67%	3.28%	3.38%	3.38%	3.38%	3.38%	3.38%	3.38%	3.38%
6	Policy		-1.40%	-1.44%	-1.45%	-1.45%	-1.45%	-1.45%	-1.45%	-1.45%	-1.45%
7	Subtot		1.27%	1.84%	1.93%	1.93%	1.93%	1.93%	1.93%	1.93%	1.93%
8	Slippage		0.03%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
9	Casemix		0.98%	0.98%	0.98%	0.98%	0.98%	0.98%	0.98%	0.98%	0.98%
10	Subtot		2.28%	2.82%	2.91%	2.91%	2.91%	2.91%	2.91%	2.91%	2.91%
11	Volume		-0.23%	-0.23%	-0.23%	-0.23%	-0.23%	-0.23%	-0.23%	-0.23%	-0.23%
12	**Total Update**		**2.05%**	**2.59%**	**2.68%**	**2.68%**	**2.68%**	**2.68%**	**2.68%**	**2.68%**	**2.68%**
13	**Inpatient Update**		**1.82%**	**2.37%**	**2.46%**	**2.46%**	**2.46%**	**2.46%**	**2.46%**	**2.46%**	**2.46%**

		2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
	Medicare Update										
14	MB		2.30%	2.90%	3.00%	3.00%	3.00%	3.00%	3.00%	3.00%	3.00%
15	Outlier		0.40%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
16	DSH		0.00%	0.00%	0.00%	0.00%	-0.47%	-0.47%	-0.47%	-0.47%	0.00%
17	Reform		-0.25%	-0.25%	-0.10%	-0.10%	-0.30%	-0.20%	-0.20%	-0.75%	-0.75%
18	Productivity		0.00%	0.00%	-1.30%	-1.30%	-1.30%	-1.30%	-1.30%	-1.30%	-1.30%
19	Medicare Comm.		0.00%	0.00%	0.00%	0.00%	-0.50%	-0.50%	-0.25%	-0.25%	-0.50%
20	Coding Retro		-1.93%	0.00%	0.00%	1.93%	0.00%	0.00%	0.00%	0.00%	0.00%
21	Coding Prosp		0.00%	-1.50%	-1.00%	-3.00%	0.00%	0.00%	0.00%	0.00%	0.00%
22	Case mix		1.00%	0.50%	0.50%	0.50%	0.50%	0.50%	0.50%	0.50%	0.50%
	Total Medicare Update		**1.52%**	**1.65%**	**1.10%**	**1.03%**	**0.93%**	**1.03%**	**1.28%**	**0.73%**	**0.95%**
23	Unadjusted Waiver	9.46%	13.88%	12.12%	10.70%	9.01%	7.89%	6.02%	6.42%	7.06%	6.65%
24	MSP & MA adj.	4.70%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
25	Medicare Slower Growth		0.18%	0.23%	0.23%	0.23%	0.23%	0.23%	0.23%	0.23%	0.23%
26	ODS adj.	-0.28%	-0.56%	-0.56%	-0.56%	-0.56%	-0.56%	0.00%	0.00%	0.00%	0.00%
27	UC Markup		-0.44%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
28	Assessment		-0.64%	-0.36%	0.00%	0.64%	0.00%	0.00%	0.00%	0.00%	0.00%
29	MHIP		0.00%	0.00%	0.00%	0.00%	0.00%	0.50%	0.50%	0.00%	0.00%
30	UC Reduction		0.00%	0.00%	0.00%	0.00%	0.00%	1.09%	1.09%	1.09%	1.09%
31	**Update Erosion vs. Medicare**		**-0.30%**	**-0.72%**	**-1.36%**	**-1.43%**	**-1.53%**	**-1.43%**	**-1.18%**	**-1.73%**	**-1.51%**
32	Total Waiver Erosion		-1.76%	-1.42%	-1.69%	-1.12%	-1.86%	0.39%	0.64%	-0.41%	-0.19%
33	**Waiver Cushion**	**13.88%**	**12.12%**	**10.70%**	**9.01%**	**7.89%**	**6.02%**	**6.42%**	**7.06%**	**6.65%**	**6.46%**
34	NOR/EIPA	-1.21%	-2.15%	-3.32%	-4.51%	-5.68%	-6.84%	-7.99%	-9.12%	-10.24%	-11.34%
35	NPR/EIPA	0.38%	-0.57%	-1.76%	-2.97%	-4.17%	-5.35%	-6.52%	-7.67%	-8.81%	-9.93%
36	**Cost/EIPA**	-0.11%	-0.96%	-2.02%	-3.09%	-4.16%	**-5.21%**	-6.26%	-7.29%	-8.31%	-8.31%

Summary of Results: Peg Medicaid Budget Update

Line		2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Avg Chg.
37	Outperform US (positive=outperform)		-0.98%	-1.23%	-1.27%	-1.27%	-1.27%	-1.27%	-1.27%	-1.27%	-1.27%	-1.23%
38	Waiver Erosion		-1.76%	-1.42%	-1.69%	-1.12%	-1.86%	0.39%	0.64%	-0.41%	-0.19%	-0.82%
39	Net Patient Revenue	$11,969	$12,415	$12,944	$13,508	$14,096	$14,710	$15,350	$16,018	$16,716	$17,444	
40	Total Operating Cost (Mill $)	$12,199	$12,652	$13,192	$13,766	$14,366	$14,991	$15,644	$16,325	$17,036	$17,778	5 yr saving
41	Cost Savings vs US Growth (Mill $) (negative numbers = dissavings)		$120	$282	$465	$667	$887	$1,127	$1,390	$1,675	$1,986	$2,421 9 yr saving
42	Position vs US Cost/EIPA						-5.21%					$8,599
43	Medicaid Share	17.50%	18.00%	18.50%	19.00%	19.50%	20.00%	20.00%	20.00%	20.00%	20.00%	
44	Medicaid Pmts	$2,095	$2,235	$2,395	$2,566	$2,749	$2,942	$3,070	$3,204	$3,343	$3,489	5 yr saving
45	Savings vs. US Growth	$0	$21	$51	$87	$128	$174	$221	$273	$329	$390	$461
46	**Waiver Cushion**	**13.88%**	**12.12%**	**10.70%**	**9.01%**	**7.89%**	**6.02%**	**6.42%**	**7.06%**	**6.65%**	**6.46%**	
47	**Cost per EIPA Position vs US**	**-0.11%**	**-0.96%**	**-2.02%**	**-3.09%**	**-4.16%**	**-5.21%**	**-6.26%**	**-7.29%**	**-8.31%**	**-8.31%**	

Exhibit 1d: Updated Medicare Cushion and NOR, NPR and Cost per EIPA Position

Target 6.0% Below Cost	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Line #										
1 NPR Growth Nationally		3.03%	3.82%	3.96%	3.96%	3.96%	3.96%	3.96%	3.96%	3.96%
2 MD Update = MB +/-		-0.38%	-0.51%	-0.51%	-0.51%	-0.51%	-0.51%	-0.51%	-0.51%	-0.51%
Maryland										
3 MB		2.29%	2.90%	3.00%	3.00%	3.00%	3.00%	3.00%	3.00%	3.00%
4 Error		0.38%	0.38%	0.38%	0.38%	0.38%	0.38%	0.38%	0.38%	0.38%
5 Subtot		2.67%	3.28%	3.38%	3.38%	3.38%	3.38%	3.38%	3.38%	3.38%
6 Policy		-1.54%	-1.64%	-1.64%	-1.64%	-1.64%	-1.64%	-1.64%	-1.64%	-1.64%
7 Subtot		1.13%	1.64%	1.74%	1.74%	1.74%	1.74%	1.74%	1.74%	1.74%
8 Slippage		0.03%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
9 Casemix		0.98%	0.98%	0.98%	0.98%	0.98%	0.98%	0.98%	0.98%	0.98%
10 Subtot		2.14%	2.62%	2.72%	2.72%	2.72%	2.72%	2.72%	2.72%	2.72%
11 Volume		-0.23%	-0.23%	-0.23%	-0.23%	-0.23%	-0.23%	-0.23%	-0.23%	-0.23%
12 **Total Update**		**1.91%**	**2.39%**	**2.49%**	**2.49%**	**2.49%**	**2.49%**	**2.49%**	**2.49%**	**2.49%**
13 **Inpatient Update**		**1.68%**	**2.17%**	**2.27%**	**2.27%**	**2.27%**	**2.27%**	**2.27%**	**2.27%**	**2.27%**

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Medicare Update										
14 MB		2.30%	2.90%	3.00%	3.00%	3.00%	3.00%	3.00%	3.00%	3.00%
15 Outlier		0.40%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
16 DSH		0.00%	0.00%	0.00%	0.00%	-0.47%	-0.47%	-0.47%	-0.47%	0.00%
17 Reform		-0.25%	-0.25%	-0.10%	-0.10%	-0.30%	-0.20%	-0.20%	-0.75%	-0.75%
18 Productivity		0.00%	0.00%	-1.30%	-1.30%	-1.30%	-1.30%	-1.30%	-1.30%	-1.30%
19 Medicare Comm.		0.00%	0.00%	0.00%	0.00%	-0.50%	-0.50%	-0.25%	-0.25%	-0.50%
20 Coding Retro		-1.93%	0.00%	0.00%	1.93%	0.00%	0.00%	0.00%	0.00%	0.00%
21 Coding Prosp		0.00%	-1.50%	-1.00%	-3.00%	0.00%	0.00%	0.00%	0.00%	0.00%
22 Case mix		1.00%	0.50%	0.50%	0.50%	0.50%	0.50%	0.50%	0.50%	0.50%
Total Medicare Update		**1.52%**	**1.65%**	**1.10%**	**1.03%**	**0.93%**	**1.03%**	**1.28%**	**0.73%**	**0.95%**
23 Unadjusted Waiver	9.46%	13.88%	12.01%	10.92%	9.19%	8.02%	6.12%	6.47%	7.07%	6.61%
24 MSP & MA adj.	4.70%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
25 Medicare Slower Growth		0.17%	0.21%	0.22%	0.22%	0.22%	0.22%	0.22%	0.22%	0.22%
26 ODS adj.	-0.28%	-0.56%	-0.56%	-0.56%	-0.56%	-0.56%	0.00%	0.00%	0.00%	0.00%
27 UC Markup		-0.44%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
28 Assessment		-0.64%	0.00%	0.00%	0.64%	0.00%	0.00%	0.00%	0.00%	0.00%
29 MHIP		0.00%	0.00%	0.00%	0.00%	0.00%	0.50%	0.50%	0.00%	0.00%
30 UC Reduction		0.00%	0.00%	0.00%	0.00%	0.00%	1.09%	1.09%	1.09%	1.09%
31 **Update Erosion vs. Medicare**		**-0.39%**	**-0.74%**	**-1.39%**	**-1.46%**	**-1.56%**	**-1.46%**	**-1.21%**	**-1.76%**	**-1.54%**
32 Total Waiver Erosion		-1.86%	-1.09%	-1.73%	-1.16%	-1.90%	0.35%	0.60%	-0.45%	-0.23%
33 **Waiver Cushion**	**13.88%**	**12.01%**	**10.92%**	**9.19%**	**8.02%**	**6.12%**	**6.47%**	**7.07%**	**6.61%**	**6.38%**
34 NOR/EIPA	-1.21%	-2.29%	-3.63%	-4.99%	-6.33%	-7.65%	-8.95%	-10.23%	-11.50%	-12.74%
35 NPR/EIPA	0.38%	-0.71%	-2.08%	-3.46%	-4.82%	-6.17%	-7.49%	-8.79%	-10.08%	-11.35%
36 **Cost/EIPA**	-0.11%	-1.09%	-2.32%	-3.56%	-4.79%	**-6.00%**	-7.19%	-8.37%	-9.53%	-9.53%

Summary of Results: 6.0% Cost Target by 2015

Line	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Avg.
37 Outperform US (positive=outperform)		-1.12%	-1.43%	-1.47%	-1.47%	-1.47%	-1.47%	-1.47%	-1.47%	-1.47%	-1.42%
38 Waiver Erosion		-1.86%	-1.09%	-1.73%	-1.16%	-1.90%	0.35%	0.60%	-0.45%	-0.23%	-0.83%
39 Net Patient Revenue	$11,969	$12,398	$12,901	$13,438	$13,997	$14,579	$15,186	$15,817	$16,475	$17,161	
40 Total Operating Cost (Mill $)	$12,199	$12,635	$13,148	$13,695	$14,265	$14,859	$15,477	$16,120	$16,791	$17,490	/5 yr saving
41 Cost Savings vs US Growth (Mill $)		$137	$326	$537	$767	$1,020	$1,295	$1,594	$1,920	$2,274	$2,786
(negative numbers = dissavings)											9 yr savings
42 Position vs US Cost/EIPA						-6.00%					$9,870
43 Medicaid Share	17.50%	18.00%	18.50%	19.00%	19.50%	20.00%	20.00%	20.00%	20.00%	20.00%	
44 Medicaid Pmts	$2,095	$2,232	$2,387	$2,553	$2,729	$2,916	$3,037	$3,163	$3,295	$3,432	5 yr Savings
45 Savings vs. US Growth	$0	$24	$59	$100	$147	$200	$254	$313	$377	$446	$530
46 **Waiver Cushion**	**13.88%**	**12.01%**	**10.92%**	**9.19%**	**8.02%**	**6.12%**	**6.47%**	**7.07%**	**6.61%**	**6.38%**	
47 **Cost per EIPA Position vs US**	**-0.11%**	**-1.09%**	**-2.32%**	**-3.56%**	**-4.79%**	**-6.00%**	**-7.19%**	**-8.37%**	**-9.53%**	**-9.53%**	

Summary Results

	Average MD outperform US per yr	Average Waiver Erosion	Years to Fail Waiver Test	5 Year (FY 11-15) Cost Savings (Dissavings) vs. US Growth $ Millions	9 Year (FY 11-19) Cost Savings (Dissavings) vs. US Growth $ Millions	Year 5 Postion vs. US on cost per Case	5 Year (FY 11-15) Medicaid Savings $ Millions
MHA	-0.27%	-1.66%	7	$459	$1,855	-0.92% Below	$88
Payers	-1.84%	-0.24%	20+ yrs	$3,568	**$12,581** *	-7.78% Below	$679
Peg Medicaid	-1.23%	-0.82%	15	$2,421	$8,599	-5.21% Below	$461
6.0% Cost Target	-1.42%	-0.83%	17	$2,786	$9,870	-6.00% Below	$530

* Similar Magnitude savings to what achieved 1976-2007 ($40 billion cost savings vs. US over 31 years or $1.3 billion on average per year)

Health Services Cost Review Commission

Report on the Results of the Uncompensated Care Policy for Fiscal Year 2011

July 7, 2010

Introduction

The purpose of this report is to present the results of the Uncompensated Care Policy for fiscal year 2011 and to update the Commission on discussions surrounding the Uncompensated Care Policy.

The HSCRC's provision for uncompensated care in hospital rates is one of the unique features of rate regulation in Maryland. Uncompensated care includes bad debt and charity care. By recognizing reasonable levels of bad debt and charity care in hospital rates, the system enhances access to hospital care for those citizens who cannot pay for care. The uncompensated care provision in rates is applied prospectively and is meant to be predictive of actual uncompensated care costs in a given year.

The HSCRC uses a regression methodology as a vehicle to predict actual uncompensated care costs in a given year. The uncompensated care methodology has undergone substantial changes over the years since it was initially established. The most recent version of the policy was adopted by the Commission on May 2, 2007.

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

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

Discussions surrounding the Uncompensated Care Policy

In the last three months, a number of hospital representatives have met with staff to discuss various issues related to the uncompensated care methodology. Most of the discussions have focused on the impact of the ongoing Medicaid expansion and the economy on the stability of the uncompensated care regression estimates. Discussions have also taken place on the difficulty of reconciliation and settlement of monies associated with "averted bad debt" and on reconstituting the explanatory variables used in the uncompensated care regression.

There were also suggestions for revising the regression model as presented by representatives from the Johns Hopkins Medical System and Mercy Medical Center at the Maryland Hospital Association's April 15, 2010 Financial Technical Issues Task Force meeting. A subsequent meeting was held by hospital representatives at the behest of MHA to further discuss the proposal on April 21, 2010.

A meeting was also held on May 6, 2010 between the HSCRC staff and hospital representatives to discuss possible recommendations from the MHA. On June 21, 2010, the MHA sent a letter (see attached) to HSCRC staff recommending "adding the final FY 2009 hospital-specific averted UCC best estimates to the reported UCC, and then proceeding with the regression and subsequent calculations," based on the June 9, 2010, report to the Commission.

The uncompensated care model

The model remains as specified in the current methodology. The amount of uncompensated care in rates is computed as follows:

1. Compute a three-year moving average for uncompensated care for each hospital.
2. Use the most recent three years of data to compute the uncompensated care regression (while adding "dummy" variables for each year).
3. Generate a predicted value for the hospital's uncompensated care rate based on the last available year of data.
4. Compute a 50/50 blend of the predicted and three-year moving average as the hospital's amount in rates.
5. Calculate the statewide amount of uncompensated care in rates from this process, and generate the percentage difference between the preliminary amount in rates and the last year of actual experience.
6. Add/subtract the statewide difference (step 5) to the hospital's preliminary UCC rate (step 4) to get adjusted rates that tie to the State's last year of actual UCC experience.

The result is the hospital's UCC rate for the next fiscal year.

Medicaid's expansion and "averted bad debts"

To account for the impact of Medicaid's expansion and "averted bad debts" on the UCC policy, staff is now using a methodology that parallels the Commission-approved method for handling uncompensated care resulting from the previous imposition of day-limits in State Medicaid reimbursement to acute care hospitals. Under that methodology, adjustments were made to the UCC policy by removing the pre-funded amounts in rates for day limits from actual uncompensated care prior to calculating the model described above. The pre-funded amounts were then added to the UCC rate calculated in step 6 to finance the day limits portion separately. Therefore, the impact of Medicaid's expansion and "averted bad debts" is accounted for by adding the "FY 2009 hospital-specific averted UCC best estimates" to hospital reported UCC and then applying the regression and other subsequent calculations. "FY 2009 hospital-specific averted UCC best estimates" refers to the hospital reconciled amount attributable to the ongoing Medicaid expansion based on the most current data available as of the date of this report.

Newly estimated "averted bad debts" for each hospital will be calculated and the UCC policy results adjusted for these new estimates before the 100 percent UCC pooling methodology is applied. The new uncompensated care provisions will become effective on July 1, 2010 with the new charge per case targets.

Result

The result of this approach is that the prospective amount built into rates across the industry is the amount actually experienced in the last year of available data excluding any new estimates for averted bad debt due to Medicaid expansion. If, for example, uncompensated care were $1 billion in fiscal year 2009, this model would establish rates that would deliver $1 billion in fiscal year 2011 if volumes and rates remain the same.

Table 1 provides summary results of the UCC policy for Fiscal Year 2011 without additional expected offset for FY 2011 averted bad debt due to Medicaid expansion. Table 2 shows the results from the regression analysis and revenue neutrality adjustment. Table 3 provides details of the fiscal year 2009 data used in the regression model. Table 4 provides a statistical summary of the variables and regression results.

Final results will be available when hospitals and their representatives have reviewed and validated the data used in this report.

Table 1
Summary Results of the UCC Model for FY 2011 (Without Additional Expected Offset for FY 2011 Averted Bad Debt due to Medicaid Expansion)

Hospid	Hospital Name	UCC Provision for FY 2011
210001	Washington County Hospital	8.03%
210002	Univ. of Maryland Medical System	9.68%
210003	Prince Georges Hospital	15.15%
210004	Holy Cross Hospital of Silver Spring	7.72%
210005	Frederick Memorial Hospital	6.63%
210006	Harford Memorial Hospital	11.03%
210007	St. Josephs Hospital	3.72%
210008	Mercy Medical Center, Inc.	8.06%
210009	Johns Hopkins Hospital	6.55%
210010	Dorchester General Hospital	8.54%
210011	St. Agnes Hospital	7.79%
210012	Sinai Hospital	8.01%
210013	Bon Secours Hospital	17.60%
210015	Franklin Square Hospital	8.85%
210016	Washington Adventist Hospital	9.37%
210017	Garrett County Memorial Hospital	8.85%
210018	Montgomery General Hospital	6.74%
210019	Peninsula Regional Medical Center	6.75%
210022	Suburban Hospital Association,Inc	5.36%
210023	Anne Arundel General Hospital	4.86%
210024	Union Memorial Hospital	6.53%
210025	The Memorial Hospital	6.34%
210027	Braddock Hospital	5.18%
210028	St. Marys Hospital	7.79%
210029	Johns Hopkins Bayview Med. Center	9.36%
210030	Chester River Hospital Center	9.30%
210032	Union Hospital of Cecil County	9.25%
210033	Carroll County General Hospital	6.11%
210034	Harbor Hospital Center	10.24%
210035	Civista Medical Center	7.84%
210037	Memorial Hospital at Easton	6.21%
210038	Maryland General Hospital	13.12%
210039	Calvert Memorial Hospital	7.33%
210040	Northwest Hospital Center, Inc.	8.31%
210043	North Arundel General Hospital	8.41%
210044	Greater Baltimore Medical Center	3.94%
210045	McCready Foundation, Inc.	10.07%
210048	Howard County General Hospital	6.83%
210049	Upper Chesepeake Medical Center	7.09%
210051	Doctors Community Hospital	10.16%
210054	Southern Maryland Hospital	9.00%
210055	Laurel Regional Hospital	11.77%
210056	Good Samaritan Hospital	6.16%
210057	Shady Grove Adventist Hospital	7.97%
** 210058	James Lawrence Kernan Hospital	4.80%
210060	Fort Washington Medical Center	12.79%
210061	Atlantic General Hospital	6.47%
	STATE-WIDE	7.79%

***** James Lawrence Kernan Hospital was excluded in the Regression Analysis***

Table 2

Policy Results from the Regression and Revenue Neutrality Adjustment for FY 2011

Hospid	Hospital Name	UCC in Rates (July 1, 2008)	Actual UCC for FY '09	Adjusted UCC for FY '09 (Includes Averted Bad Debt)	Predicted UCC	FY '07 - FY '09 UCC AVERAGE	50/ 50 BLENDED UCC AVERAGE	Revenue Neutrality Adjustment	Policy Results	Dollar Amount
210001	Washington County Hospital	6.67%	8.52%	8.93%	7.60%	8.09%	7.84%	0.19%	8.03%	19,520,103
210002	Univ. of Maryland Medical System	8.69%	9.18%	9.73%	9.39%	9.58%	9.48%	0.19%	9.68%	90,956,801
210003	Prince Georges Hospital	13.35%	15.62%	16.06%	14.58%	15.33%	14.96%	0.19%	15.15%	39,468,386
210004	Holy Cross Hospital of Silver Spring	6.43%	7.57%	7.81%	7.81%	7.24%	7.53%	0.19%	7.72%	30,444,995
210005	Frederick Memorial Hospital	5.62%	5.77%	6.22%	6.97%	5.92%	6.44%	0.19%	6.63%	17,704,449
210006	Harford Memorial Hospital	8.24%	11.76%	12.09%	10.32%	11.35%	10.83%	0.19%	11.03%	10,610,783
210007	St. Josephs Hospital	2.81%	4.09%	4.18%	3.44%	3.63%	3.53%	0.19%	3.72%	14,855,320
210008	Mercy Medical Center, Inc.	7.79%	7.98%	8.35%	7.88%	7.86%	7.87%	0.19%	8.06%	30,817,744
210009	Johns Hopkins Hospital	5.65%	6.60%	6.78%	6.49%	6.22%	6.35%	0.19%	6.55%	106,059,065
210010	Dorchester General Hospital	8.25%	8.28%	9.20%	9.17%	7.54%	8.35%	0.19%	8.54%	4,506,124
210011	St. Agnes Hospital	7.07%	6.28%	6.72%	8.60%	6.59%	7.60%	0.19%	7.79%	27,950,282
210012	Sinai Hospital	7.06%	7.74%	8.03%	7.69%	7.95%	7.82%	0.19%	8.01%	50,257,665
210013	Bon Secours Hospital	13.68%	17.93%	18.30%	18.35%	16.47%	17.41%	0.19%	17.60%	21,494,275
210015	Franklin Square Hospital	7.93%	7.26%	7.83%	9.17%	8.15%	8.66%	0.19%	8.85%	36,717,174
210016	Washington Adventist Hospital	7.29%	8.64%	9.01%	8.84%	9.52%	9.18%	0.19%	9.37%	26,640,483
210017	Garrett County Memorial Hospital	8.08%	9.14%	10.20%	8.68%	8.65%	8.66%	0.19%	8.85%	3,259,496
210018	Montgomery General Hospital	6.03%	6.02%	6.17%	7.20%	5.90%	6.55%	0.19%	6.74%	9,478,173
210019	Peninsula Regional Medical Center	5.56%	6.45%	6.90%	6.66%	6.45%	6.55%	0.19%	6.75%	25,987,478
210022	Suburban Hospital Association,Inc	4.71%	5.09%	5.18%	5.40%	4.93%	5.17%	0.19%	5.36%	12,227,044
210023	Anne Arundel General Hospital	4.36%	4.28%	4.31%	4.95%	4.39%	4.67%	0.19%	4.86%	19,075,896
210024	Union Memorial Hospital	6.33%	6.23%	6.59%	5.85%	6.83%	6.34%	0.19%	6.53%	27,041,825
210025	The Memorial Hospital	4.86%	4.55%	5.35%	6.76%	5.54%	6.15%	0.19%	6.34%	6,736,665
210027	Braddock Hospital	4.06%	5.03%	5.60%	4.91%	5.07%	4.99%	0.19%	5.18%	8,640,855
210028	St. Marys Hospital	6.51%	5.41%	5.86%	9.16%	6.04%	7.60%	0.19%	7.79%	9,668,928
210029	Johns Hopkins Bayview Med. Center	8.68%	10.49%	11.05%	8.54%	9.81%	9.17%	0.19%	9.36%	48,086,357
210030	Chester River Hospital Center	7.39%	10.60%	11.26%	6.48%	11.73%	9.11%	0.19%	9.30%	5,664,419
210032	Union Hospital of Cecil County	7.89%	10.10%	10.95%	9.56%	8.55%	9.06%	0.19%	9.25%	11,725,479
210033	Carroll County General Hospital	5.17%	4.46%	4.94%	6.74%	5.09%	5.92%	0.19%	6.11%	11,985,072
210034	Harbor Hospital Center	9.05%	8.58%	9.23%	11.00%	9.09%	10.05%	0.19%	10.24%	20,568,875
210035	Civista Medical Center	6.10%	6.02%	6.50%	9.01%	6.29%	7.65%	0.19%	7.84%	8,123,830
210037	Memorial Hospital at Easton	5.92%	4.95%	5.47%	6.83%	5.20%	6.01%	0.19%	6.21%	9,931,215
210038	Maryland General Hospital	11.59%	13.14%	13.87%	13.17%	12.68%	12.93%	0.19%	13.12%	23,857,180
210039	Calvert Memorial Hospital	6.14%	5.86%	6.32%	8.40%	5.88%	7.14%	0.19%	7.33%	8,162,657
210040	Northwest Hospital Center, Inc.	7.30%	8.28%	8.60%	8.22%	8.03%	8.12%	0.19%	8.31%	17,603,988
210043	North Arundel General Hospital	6.73%	8.01%	8.40%	8.44%	8.00%	8.22%	0.19%	8.41%	26,020,749
210044	Greater Baltimore Medical Center	2.54%	2.87%	3.08%	4.67%	2.83%	3.75%	0.19%	3.94%	15,500,419
210045	McCready Foundation, Inc.	6.84%	10.39%	11.26%	10.04%	9.73%	9.88%	0.19%	10.07%	1,694,190
210048	Howard County General Hospital	5.73%	5.70%	5.99%	7.80%	5.48%	6.64%	0.19%	6.83%	15,765,851
210049	Upper Chesepeake Medical Center	5.47%	6.97%	7.27%	7.43%	6.37%	6.90%	0.19%	7.09%	15,567,723
210051	Doctors Community Hospital	8.25%	9.61%	10.04%	9.83%	10.11%	9.97%	0.19%	10.16%	19,172,518
210054	Southern Maryland Hospital	7.39%	8.05%	8.42%	8.80%	8.81%	8.80%	0.19%	9.00%	20,223,906
210055	Laurel Regional Hospital	11.07%	11.53%	12.02%	11.10%	12.05%	11.58%	0.19%	11.77%	10,784,190
210056	Good Samaritan Hospital	5.72%	5.30%	5.71%	6.27%	5.67%	5.97%	0.19%	6.16%	17,638,476
210057	Shady Grove Adventist Hospital	6.60%	6.92%	7.24%	8.41%	7.15%	7.78%	0.19%	7.97%	26,394,538
** 210058	James Lawrence Kernan Hospital	6.30%	7.54%	7.86%	2.65%	6.95%	4.80%	0.00%	4.80%	5,078,676
210060	Fort Washington Medical Center	9.60%	14.68%	15.07%	11.46%	13.73%	12.60%	0.19%	12.79%	6,041,966
210061	Atlantic General Hospital	5.64%	6.21%	6.67%	6.68%	5.89%	6.28%	0.19%	6.47%	4,952,323
	STATE-WIDE	6.73%	7.42%	7.79%	7.77%	7.43%	7.60%	0.19%	7.79%	1,000,664,606

***** James Lawrence Kernan Hospital was excluded in the Regression Analysis***

Table 3

Fiscal Year 2009 Data Used in Regression for FY 2011

Hospid	Hospital Name	Inpatient Medicaid Charges	Inpatient Non-Medicare Charges through the ER	Inpatient Self-Pay and Charity Charges	Outpatient Medicaid Charges through the ER	Outpatient Self -Pay and Charity Charges through the ER	Outpatient Revenue	UCC in Rates (July 1, 2008)	Gross Patient Revenue	Uncompensated Care
210001	Washington County Hospital	15,952,474	38,632,899	7,589,685	5,408,649	6,109,283	84,404,900	6.67%	$243,018,300	$21,593,368
210002	Univ. of Maryland Medical System	156,245,288	211,979,816	28,714,728	20,154,582	12,315,254	230,738,600	8.69%	$940,100,100	$94,995,091
210003	Prince Georges Hospital	63,962,391	87,265,226	10,231,269	5,709,816	10,991,631	55,608,200	13.35%	$260,576,400	$42,154,785
210004	Holy Cross Hospital of Silver Spring	50,300,641	72,057,998	14,009,580	5,637,406	6,592,324	104,017,600	6.43%	$394,466,500	$30,778,789
210005	Frederick Memorial Hospital	16,663,408	44,789,815	7,344,206	4,025,617	4,047,916	97,939,200	5.62%	$266,844,200	$15,936,769
210006	Harford Memorial Hospital	6,105,545	23,121,858	2,135,544	2,896,062	3,232,698	36,652,600	8.24%	$96,235,600	$11,641,401
210007	St. Josephs Hospital	13,845,556	44,266,439	7,684,253	1,959,318	2,819,792	104,312,600	2.81%	$398,844,400	$16,656,827
210008	Mercy Medical Center, Inc.	53,470,919	39,763,371	4,712,857	10,215,339	7,265,630	172,493,300	7.79%	$382,169,900	$32,245,015
210009	Johns Hopkins Hospital	238,447,216	203,793,243	9,290,264	23,864,212	16,266,132	532,549,400	5.65%	$1,620,280,400	$115,203,491
210010	Dorchester General Hospital	4,799,161	8,208,569	1,381,188	1,990,566	1,377,072	22,093,700	8.25%	$52,734,300	$4,671,120
210011	St. Agnes Hospital	39,588,328	69,594,308	13,158,174	8,259,139	6,945,992	106,315,300	7.07%	$358,890,700	$23,693,638
210012	Sinai Hospital	74,688,549	91,976,620	4,700,656	17,154,584	11,601,406	215,542,000	7.06%	$627,278,200	$51,450,780
210013	Bon Secours Hospital	23,302,229	39,995,914	10,790,145	7,596,937	8,070,408	40,612,800	13.68%	$122,144,200	$22,233,042
210015	Franklin Square Hospital	51,714,900	87,927,827	10,213,789	10,892,263	8,053,135	119,994,200	7.93%	$414,987,900	$32,241,273
210016	Washington Adventist Hospital	34,902,387	60,487,456	13,133,638	4,272,179	6,973,154	67,428,566	7.29%	$284,247,984	$25,335,354
210017	Garrett County Memorial Hospital	2,569,214	5,106,360	760,044	1,316,094	995,786	17,444,100	8.08%	$36,812,400	$3,626,040
210018	Montgomery General Hospital	8,131,948	28,869,822	4,488,155	1,842,120	2,049,850	41,711,400	6.03%	$140,619,400	$8,759,201
210019	Peninsula Regional Medical Center	29,619,422	57,572,291	11,512,770	7,138,622	5,920,880	122,608,300	5.56%	$385,277,000	$25,923,176
210022	Suburban Hospital Association,Inc	8,209,895	44,127,946	4,995,636	870,181	1,788,476	61,005,500	4.71%	$228,243,300	$11,850,343
210023	Anne Arundel General Hospital	20,659,710	50,459,440	6,304,903	3,275,172	4,042,253	132,999,100	4.36%	$392,507,100	$17,321,674
210024	Union Memorial Hospital	40,583,803	60,899,926	8,631,913	5,324,091	5,188,219	100,221,800	6.33%	$413,847,100	$27,152,228
210025	The Memorial Hospital	11,785,336	13,764,163	2,007,720	2,663,060	1,374,985	33,350,500	4.86%	$106,194,800	$5,500,327
210027	Braddock Hospital	6,930,410	17,588,088	3,325,686	1,092,822	824,958	79,602,300	4.06%	$166,869,000	$8,772,799
210028	St. Marys Hospital	9,293,320	22,882,844	3,666,776	3,982,189	2,452,100	54,536,400	6.51%	$124,100,600	$7,164,802
210029	Johns Hopkins Bayview Med. Center	71,125,805	86,667,581	18,193,203	8,808,268	10,707,631	173,521,800	8.68%	$513,495,600	$55,718,584
210030	Chester River Hospital Center	3,436,824	6,056,727	1,072,467	1,353,039	1,182,703	29,086,800	7.39%	$60,914,200	$6,740,590
210032	Union Hospital of Cecil County	12,546,014	17,520,386	3,244,674	5,020,856	4,061,508	58,238,200	7.89%	$126,780,200	$12,973,214
210033	Carroll County General Hospital	14,129,715	42,676,156	301,680	2,459,772	2,177,565	50,496,400	5.17%	$196,154,700	$9,199,746
210034	Harbor Hospital Center	35,035,129	45,075,760	6,591,080	7,339,924	5,284,135	50,840,100	9.05%	$200,915,200	$18,278,859
210035	Civista Medical Center	7,796,477	21,574,481	2,906,586	2,865,755	2,525,992	35,240,700	6.10%	$103,621,000	$6,558,625
210037	Memorial Hospital at Easton	13,744,371	20,378,409	3,027,840	3,368,904	2,765,253	61,997,900	5.92%	$160,032,300	$8,680,775
210038	Maryland General Hospital	56,783,529	47,535,543	5,356,870	4,723,381	4,002,021	42,813,000	11.59%	$181,868,000	$24,647,960
210039	Calvert Memorial Hospital	7,400,040	20,900,312	2,389,963	2,811,722	1,756,944	48,468,900	6.14%	$111,417,900	$6,762,052
210040	Northwest Hospital Center, Inc.	16,245,186	36,683,583	1,345,729	6,197,434	4,767,011	82,674,300	7.30%	$211,714,700	$18,004,572
210043	North Arundel General Hospital	15,308,972	62,717,014	9,045,149	6,552,618	9,170,935	106,197,100	6.73%	$309,341,800	$25,485,722
210044	Greater Baltimore Medical Center	13,815,354	47,179,356	3,068,008	3,436,144	2,565,757	161,811,600	2.54%	$393,162,100	$11,689,422
210045	McCready Foundation, Inc.	486,406	1,224,611	426,331	1,136,093	720,464	10,582,069	6.84%	$16,819,985	$2,028,739
210048	Howard County General Hospital	17,381,065	42,202,983	4,965,648	4,392,680	4,412,360	84,099,600	5.73%	$230,685,500	$13,889,857
210049	Upper Chesepeake Medical Center	11,630,699	42,905,186	1,729,814	4,123,845	3,944,147	79,900,400	5.47%	$219,562,700	$15,777,938
210051	Doctors Community Hospital	13,847,690	43,847,986	4,397,256	4,484,208	5,328,727	74,494,100	8.25%	$188,720,500	$18,712,956
210054	Southern Maryland Hospital	22,780,234	46,802,593	8,922,996	5,496,723	4,224,846	64,202,100	7.39%	$224,831,800	$18,541,942
210055	Laurel Regional Hospital	11,435,159	21,086,616	2,093,103	2,109,332	4,029,663	32,799,700	11.07%	$91,640,000	$10,815,240
210056	Good Samaritan Hospital	24,262,041	46,127,743	5,063,008	4,404,794	3,680,740	78,515,900	5.72%	$286,296,100	$16,002,954
210057	Shady Grove Adventist Hospital	31,115,779	69,386,808	9,253,034	5,379,982	5,721,686	112,384,799	6.60%	$331,274,906	$23,967,535
** 210058	James Lawrence Kernan Hospital	4,926,932	0	841,012	0	0	36,827,500	6.30%	$105,778,700	$8,146,125
210060	Fort Washington Medical Center	1,007,917	11,141,181	2,189,825	1,277,259	2,394,929	23,677,252	9.60%	$47,242,143	$7,237,932
210061	Atlantic General Hospital	2,059,390	8,919,426	1,316,867	1,379,530	1,965,090	38,586,400	5.64%	$76,484,900	$5,101,931
	STATE-WIDE	1,390,072,778	2,213,742,680	288,525,722	246,663,283	224,689,443	4,171,638,986	6.73%	$12,846,044,718	$1,001,864,603

***** James Lawrence Kernan Hospital was excluded in the Regression Analysis***

Table 4
Statistical Summary of the Variables and Regression Results

R-Square	0.7125			
Adjusted R-Square	0.6993			
Variables:	**Parameter Estimate**	**Standard Error**	**t Value**	**P-Value (Pr > |t|)**
The proportion of a hospital's total charges from inpatient non-Medicare admissions through the emergency room	0.22859	0.03907	5.85	<.0001
The proportion of a hospital's total charges from inpatient Medicaid, self-pay, and charity cases	0.16289	0.03279	4.97	<.0001
The proportion of a hospital's total charges from outpatient Medicaid, self-pay, and charity visits to the emergency room	0.49899	0.10997	4.54	<.0001
The proportion of a hospital's total charges from outpatient charges	0.06967	0.02855	2.44	0.0160

Maryland
Hospital Association

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June 21, 2010

Andy Udom
Associate Director, Research and Methodology
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore MD 21215

Dear Mr. Udom:

On behalf of Maryland's 47 acute care hospitals, the Maryland Hospital Association (MHA) recommends that the Commission modify its method for accommodating the FY 2009 averted uncompensated care (UCC) prospective reduction in the FY 2011 UCC policy. In your June 9 *Report on Preliminary Results of the Uncompensated Care Policy for FY 2011*, you propose "...adding the estimated averted bad debts to hospital reported UCC and then applying the regression and subsequent calculations." The hospital field recommends adding the final FY 2009 hospital-specific averted UCC best estimates to the reported UCC, and then proceeding with the regression and subsequent calculations. Using the final best estimate of FY 2009, averted UCC will have a relatively small statewide effect, but a more meaningful effect on specific hospitals.

I appreciate the opportunity to comment on the UCC policy and the continued dialogue with you on this technically challenging issue. If you have any questions, please contact me.

Sincerely,

Traci Lynn La Valle

Traci La Valle
Assistant Vice President, Financial Policy

cc: Robert Murray, Executive Director, HSCRC

Title 10 DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Subtitle 37 HEALTH SERVICES COST REVIEW COMMISSION

10.37.01 Uniform Accounting and Reporting System for Hospitals and Related Institutions

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

NOTICE OF PROPOSED ACTION

The Health Services Cost Review Commission proposes to amend **Regulation .03L-1** under **COMAR 10.37.01 Uniform Accounting and Reporting System for Hospitals and Related Institutions**. This action was considered and approved for promulgation by the Commission at a previously announced open meeting held on July 7, 2010, 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 November 15, 2010.

Statement of Purpose

The purpose of this action is to extend the time frame for the submission of the annual hospital Interns and Residents Survey to the Commission from July to January.

Comparison of Federal Standards

There is no corresponding federal standard to this proposed action.

Estimate of Economic Impact

The proposed action has no economic impact.

Opportunity for Public Comment

Comments may be sent to Diana M. Kemp, Regulations Coordinator, Health Services Cost Review Commission, 4160 Patterson Avenue, Baltimore, Maryland 21215, or 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 August 30, 2010. A hearing may be held at the discretion of the Commission.

.03 Reporting Requirements; Hospitals.

A.-K. (text unchanged)

L-1. Interns and Residents Survey.

(1) Hospitals shall submit the Interns and Residents Survey to the Commission by [July 15] January 15 of every calendar year.

(2) (text unchanged)

L-2.- Q. (text unchanged)

DONALD A. YOUNG, M.D.
Chairman
Health Services Cost Review Commission

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

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TO: **Commissioners**

FROM: **Legal Department**

DATE: **June 30, 2010**

SUBJECT: **Hearing and Meeting Schedule**

Public Session

August 4, 2010	**Time to be determined, 4160 Patterson Avenue, HSCRC Conference Room**
September 1, 2010	**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 Thursday before the Commission Meeting. To review the agenda, visit the Commission's web site at www.hscrc.state.md.us