447TH MEETING OF THE
HEALTH SERVICES COST REVIEW COMMISSION

July 2, 2008

Chairman Donald A. Young, M.D., called the meeting to order at 9:00 a.m. Commissioners Joseph R. Antos, Ph.D., Trudy R. Hall, M.D., and James Lowthers were also present.

REPORT OF THE EXECUTIVE SESSION OF JUNE 4, 2008

Oscar Ibarra, Chief-Program Administration & Information Management, summarized the minutes of the June 4, 2008 Executive Session.

ITEM I
REVIEW OF THE MINUTES OF THE PUBLIC SESSION OF MAY 14, 2008

The Commission voted unanimously to approve the minutes of the June 4, 2008 Public Meeting.

COMFORT ORDER-UPPER CHESAPEAKE MEDICAL CENTER

The Commission unanimously voted to ratify its approval in Executive Session of the Upper Chesapeake Medical Center's request for a Comfort Order.

ITEM II
EXECUTIVE DIRECTOR'S REPORT

Robert Murray, Executive Director, welcomed former staff member Charlotte Thompson back as the new Associate Director- Policy Analysis and Research. Mrs. Thompson was most recently Managing Consultant for Navigant Consulting, Inc.

ITEM III
DOCKET STATUS CASES CLOSED

1976N – University Specialty Hospital
1977A – University of Maryland Medical Center
1979R – Union Hospital of Cecil County
1981R – Garrett County Memorial Hospital
1983R – Carroll Hospital Center
1984N – McCready Memorial Hospital

ITEM IV
DOCKET STATUS CASES OPEN

Greater Baltimore Medical Center – 1980R

On April 29, 2008, the Greater Baltimore Medical Center submitted a full rate application; however, because certain data were omitted, the application was not docketed until May 6, 2008. The Hospital requested that its permanent rate structure be increased by 12.59%, effective June 1, 2008. The Hospital also asked for an additional rate increase of 0.52% effective July 1, 2008 for four residents who will be added to its staff at that time. Included in the application was a request for a retroactive adjustment of 3.81% to recover the revenue that would have accrued to the Hospital if its requested rate increase had gone into effective thirty days after the expiration of the moratorium on filing full rate applications, December 1, 2007.

After review of the Hospital's application and in accordance with the HSCRC's approved methodology, staff recommended, effective June 5, 2008:

1. That the Hospital's Charge-per-Case (CPC) standard be increased by 3.72%;
2. That the Hospital's outpatient unit rates be increased by 3.68%;
3. That the Uncompensated Care Provision included in the calculation of the recommended CPC standard and outpatient unit rates remain in the Hospital's rates for 12 months;
4. That the Hospital's cap for interns and residents be increased to 63 on July 1, 2008, but that no additional revenue be included in rates unless the Hospital files a full rate application; and
5. That no retroactive adjustment be made.

The Commission voted unanimously to approve staff's recommendation.

Dorchester General Hospital – 1982N

On April 24, 2008, Dorchester General Hospital filed an application requesting a rate for its new Audiology (AUD) service. The Hospital requested that the state-wide median plus an update factor of 4% be approved effective July 1, 2008.

After review of the application, staff recommended:

1. That COMAR 10.37.10.07 requiring that rate applications be filed 60 days prior to the opening of a new service be waived;
2. That the state-wide median AUD rate of $13.33 per RVU be approved effective July 1, 2008;
3. That no change be made to the Hospital's Charge per Case standard for AUD services; and
4. That the AUD rate not be rate realigned until a full year's experience data have been reported to the Commission.

The Commission voted unanimously to approve staff's recommendation.

Johns Hopkins Health System – 1986A

On June 6, 2008, Johns Hopkins Health System filed an application on behalf of its member hospitals, Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, and Howard County General Hospital, requesting approval to continue to participate in a global rate arrangement with Atlantic Institute, Inc for cardiovascular services for one year effective April 1, 2008.

Although there was no activity under this arrangement in the last year, staff expressed confidence that the arrangement was structured so that the Hospitals could achieve favorable performance under this arrangement in the future as it has in the past. Therefore, staff recommended that the Commission approve the renewal request for one year retroactive to April 1, 2008 and that the approval be contingent upon the execution of the standard Memorandum of Understanding.

The Commission voted unanimously to approve staff's recommendation.

MedStar Health – 1987A

On June 16, 2008, MedStar Health filed an application on behalf of Union Memorial and Good Samaritan Hospitals, requesting approval to continue to participate in a global rate arrangement for cardiovascular services with the Kaiser Permanente Health Plan of the Mid-Atlantic, Inc. for a period of one year beginning September 1, 2008.

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

The Commission voted unanimously to approve staff's recommendation.

MedStar Health – 1988A

On June 16, 2008, MedStar Health submitted an application on behalf of Union Memorial and Good Samaritan Hospitals, for approval to continue to participate in a global rate arrangement for orthopedic services with MAMSI for one year beginning September 1, 2008.

Because the experience under this arrangement was favorable over the last year, staff

recommended that the Commission approve the request for one year effective September 1, 2008, and that the approval be contingent upon the execution of the standard Memorandum of Understanding.

The Commission voted unanimously to approve staff's recommendation.

Extensions

Staff requested 30 day extensions of time for review of the applications of Washington Adventist Hospital, Proceeding 1989N and Harford Memorial Hospital, Proceeding 1990R.

The Commission voted unanimously to approve staff's request.

ITEM V
FINAL RECOMMENDATIONS ON THE FINANCIAL CONDITIONS REPORT

Mr. Murray summarized the final recommendations on the Financial Conditions Report (the Report). Mr. Murray stated that the Commission, in addition to trying to ensure efficient operations, is also concerned with the financial condition of the industry. In order to fulfill this responsibility in addition to the Annual Disclosure of Hospital Financial and Statistical Information, the Commission has periodically reviewed the industry's performance versus operating targets and balance sheet indicators levels; examined the climate for hospital operations and financial performance; and examined the ability of hospitals to access capital. This Report represents the HSCRC's most recent review. Staff, with the input of the Financial Conditions Workgroup, developed a set of proposed indicators and target levels. In addition to the recommended target levels and indicators, the workgroup also interviewed a number of financial experts, individuals involved with the credit markets, to obtain their perspective on Maryland, Maryland hospitals, the rate setting system, as well as certain developments in the credit markets in the last year. Mr. Murray pointed out that the Report also contained a chart that reflects the massive recapitalization effort of the industry over the last three or four years. In general, the response of the credit market experts was very positive to the rate setting system. The "leanness" of Maryland hospitals' balance sheets is offset by the financial predictability and stability that the industry enjoys. Mr. Murray reported that the workgroup also had a discussion with Jack Ashby, formerly of ProPac and MedPac, about productivity. Mr. Murray noted that exploring how hospitals can generate productivity improvements in future years will continue to be the focus of the Commission.

Mr. Murray stated the current indicators and target levels included: 1) Operating margin at 2.75%; 2) Excess Margin at 4.0%; 3) Efficiency Target --Cost per Equivalent Admission (EIPA) -- at a range of 3% to 6% below the nation; 4) Debt to Capitalization at 0.40; 5) Days of Cash on Hand 115 days; and 6) Average Age of Plant at 8.0 years. The staff recommended that Operating Margin, Excess Margin, Average Age of Plant, and Debt to Capitalization targets be maintained

at the current levels. In addition, staff recommended: 1) that the current Days of Cash on Hand target of 115 days be maintained with the caveat that all hospitals be required to provide annually the data necessary to calculate Days of Cash on Hand, as well as the Debt to Capitalization target as they are reported to bond holders and lenders for the "Obligated Group"; 2) that its recommendation on the Efficiency Target be deferred pending further analysis regarding the calculation of the EIPA statistic; 3) that an Earnings Before Interest, Depreciation, Taxes, and Amortization (EBIDTA) ratio with a target level of 10.75% of net operating revenue be adopted; and 4) that a Debt Service Coverage (DSC) ratio with a target level of 3.0 be adopted.

Paul Sokolowski, Vice President-Finance of the Maryland Hospital Association (MHA), stated that although industry disagreed with staff's approach and believed that a financial conditions report should assess the current health of the industry, it supported the addition of the EBIDTA and DSC indicators. However, he expressed a technical concern with the DSC target, i.e., that to be mathematically internally consistent, the target should 4.0 rather than 3.0.

The Commission voted unanimously to approve staff's recommendation.

ITEM VI
FINAL RECOMMENDATIONS ON THE IMPLEMENTATION OF THE BROAD-BASED UNIFORM PROVIDER ASSESSMENT

John O'Brien, Deputy Director-Research and Methodology, presented staff's final recommendation on the Implementation of the Broad-Based Uniform Provider Assessment. Mr. O'Brien thanked the industry and MHA for their active participation in discussions on the technical aspects of the implementation of the assessment since last month's public meeting. These discussions have resulted in several modifications of the draft recommendation.

Mr. O'Brien pointed out that effective July 1, 2008, the Medicaid Program is expanding to include the parents and caretakers of children with household incomes of up to 116% of federal poverty guidelines. Medicaid estimates that this expansion to cover an additional 30,000 citizens. One of the challenges is how to adjust the uncompensated care (UCC) provisions at each hospital to reflect the expansion of Medicaid coverage. Staff decided to utilize historical data on where the children of the expansion population receive hospital services as a proxy to project where the expansion population will receive services in order to prorate the averted bad debt reduction in hospital UCC.

Mr. O'Brien noted that there are two modifications to staff's recommendation: 1) to change the methodology used to prorate the averted bad debt among hospitals from using the proxy population's share of the hospital's current UCC provision, to using the percentage of the proxy population charges to total proxy population charges for each hospital; and 2) to add an assumption for hospital expenditures outside of Maryland in the estimation of averted bad debts calculation.

Mr. O'Brien stated that the methodology used to prorate the estimated averted bad debt is reasonable and consistent with the policy used to increase hospital UCC for the State-Only and Medicaid Day Limits. Staff recognizes that there needs to be a settle-up process to ensure revenue neutrality. The settle-up for the reductions in hospitals' UCC provision for FY 2009 averted bad debts will go into FY 2011 rates. Mr. O'Brien noted that there will be two tracking activities: 1) monthly tracking of the enrollment of the new Medicaid population; and 2) tracking the actual experience of the new population through Medicaid payment data.

Ing-Jye Cheng, representing MHA, and Henry Franey, CFO of the University of Maryland Medical Center, presented comments on UCC and the Medicaid expansion. Ms. Cheng stated that the hospitals strongly support Medicaid expansion and, because of the lag in the UCC methodology, recognize the need for a process to handle the resultant UCC reductions on a more current basis. However, because it will be about two years before there will be a settle-up, we must work together over the next few months to ensure that we have a clear, accurate, transparent, and timely reconciliation process. Getting the process correct is important because we are dealing with only Phase I of a larger Medicaid expansion effort. The focus today is on two issues: 1) the forecast and allocation methodology; and 2) the tracking and reconciliation process.

Mr. Franey stated that the objective of the industry is to ensure that hospitals are not inadvertently harmed by this complex process. He noted that there are many estimates in the calculation of averted bad debt including: 1) the timing of the enrollment of the new population; 2) the timing and the amount of services provided to that population; and 3) what hospitals will provide the care. Mr. Franey pointed out that although there are parallels between the current Medicaid expansion and the Medicaid State Only and the Medicaid Day Limits Programs, there is one big difference. In both the Medicaid State Only and Day Limits Programs, hospitals could identify the participants from their own records. However, in the current Medicaid expansion, we are making educated guesses. Therefore, the hospitals are requesting that the HSCRC not make an adjustment of 100% of the projected averted bad debts, but rather make an adjustment for 80%.

Mr. Franey stated that the estimating process is only the beginning; the real work is in the settle-up. Mr. Franey asserted that in order to do the settle-up we must rely on information that neither DHMH nor hospitals currently have. The data set must come from Medicaid managed care organizations to DHMH. Mr. Franey asked that the Commissioners to keep in mind that this is a new process and to be cognizant of the problems that could occur during the reconciliation process. Mr. Franey asked that if the Commission were going to be conservative, that it be conservative in the amount removed from hospitals' UCC provision for averted bad debt.

Mr. Murray stated that Mr. Franey's comments argue for us to be collectively more vigilant and to work with DHMH and the Medicaid Program to make sure that we are tracking the eligibility and the actual encounter experience data real time. In addition, staff has proposed attempting to link-up encounter data with charge data from the HSCRC's case mix data which would provide charge data by individual hospital. Mr. Murray stated that buffering the reduction in hospitals'

UCC provision for averted bad debts by 20% would fundamentally shift the risk back to the payers. Mr. Murray stated that it is fairer and more effective for individual hospitals that can show by credible and convincing evidence that they are suffering negative financial impact from the averted bad debt reduction, to come before the Commission for relief.

Ms. Cheng stated that the industry also believes it important to work with staff and Medicaid to find a way to get patient level data so that hospitals can track averted bad debt in their hospital, and that the industry and staff continue to work so that we can agree on the reconciliation process in the next few months.

The Commission voted unanimously to approve staff's recommendation

ITEM VII
FINAL RECOMMENDATIONS ON INVASIVE RADIOLOGY-CARDIOVASCULAR RELATIVE VALUE UNITS

Rodney Spangler, Chief – Audit & Compliance, requested approval from the Commission to adopt revisions to the Relative Value Units associated with Radiology/Cardiovascular services.

The Commission voted unanimously to approve staff's request

ITEM VIII
HEARING AND MEETING SCHEDULE

August 6,, 2008	Meeting cancelled.
September 10, 2008	Time to be determined, 4160 Patterson Avenue, HSCRC Conference Room

There being no further business, the meeting was adjourned at 9:52 a.m.