446TH MEETING OF THE
HEALTH SERVICES COST REVIEW COMMISSION

June 4, 2008

Chairman Donald A. Young, M.D., called the meeting to order at 9:02 a.m. Commissioners Raymond J. Brusca, J.D., Trudy R. Hall, M.D., James Lowthers, Kevin J. Sexton, and Herbert Wong, Ph.D. 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 May 14, 2008 Public Meeting.

COMFORT ORDER- JOHNS HOPKINS HEALTH SYSTEM

The Commission unanimously voted to ratify their approval in Executive Session of the Johns Hopkins Health System's request for a Comfort Order.

ITEM II
EXECUTIVE DIRECTOR'S REPORT

Robert Murray, Executive Director, updated the Commissioners on the status of the following activities undertaken by staff: Mr. Murray reported that four recommendations would be presented at today's public meeting: 1) a final recommendation on the Quality-based Reimbursement Initiative; 2) a final recommendation on the Outpatient Revenue Constraint System; 3) a draft recommendation on the Financial Conditions Report; and 4) a draft recommendation on the Uniform Assessment related to Medicaid expansion.

In addition, Mr. Murray noted that staff's projects for the summer included: 1) review of the ROC/ICC methodologies; 2) deliberations by the Quality Evaluation Work Group focusing on outcome measures; 3) the assembling of an advisory group to consider refinement of the Community Benefits Report; and 4) creation of a work group to study physician/hospital issues.

RETIREMENT OF CAL PIERSON AS PRESIDENT OF THE MARYLAND HOSPITAL ASSOCIATION (MHA)

Chairman Young thanked Mr. Pierson for his leadership in a very collaborative working relationship with the Commission.

Mr. Pierson stated that it has been a privilege to work with the Commission representing the hospital industry for the last 17 years. Mr. Pierson agreed that collaboration is the only way that the system can continue to work well, and it has allowed us to do some very important work together. Mr. Pierson noted that another reason the system worked so well was because the Commissioners are volunteers who give their time to this very difficult and time consuming work.

Mr. Pierson also expressed the industry's support for the Maryland Patient Safety Center. Mr. Pierson thanked the Commission for their continuing financial support for its work.

Mr. Pierson introduced his successor, Carmela Coyle. Ms. Coyle will assume the presidency of MHA on July 1, 2008. Ms. Coyle was most recently Senior Vice President of the American Hospital Association and was in charge of the development of health care policy activities.

Citing her experience in working over the years with MedPac, and its precursors ProPac and the Physician Payment Review Commission, Ms. Coyle expressed her understanding of the importance of the work that the Commission does and the challenges that it faces. Ms. Coyle voiced her hope that the tradition of collaboration and collegiality that the Commission and MHA have forged will continue.

ITEM III
DOCKET STATUS CASES CLOSED

1973R - Mt. Washington Pediatric Hospital

1978R – St. Joseph Medical Center

ITEM IV
DOCKET STATUS CASES OPEN

University Specialty Hospital - 1976N

On April 9, 2008, University Specialty Hospital submitted an application requesting that new revenue be approved for Cost of Drugs Sold (CDS) overhead. Over the last fifteen years, the Hospital has contracted with NeighborCare to provide pharmacy services for its patients. As a result, unlike all other hospitals under HSCRC jurisdiction, University Specialty Hospital does not have an amount in its rate structure for approved CDS overhead. However, since the agreement with NeighborCare will be terminated, the Hospital requested CDS overhead in the

amount of $2,947,187 be approved effective June 1, 2008.

After reviewing the Hospital's application, staff recommended that the Hospital's request be approved effective June 1, 2008.

The Commission voted unanimously to approve staff's recommendation.

University of Maryland Medical Center – 1977A

On April 6, 2008, the University of Maryland Medical Center filed an application for approval to continue to participate in a global rate arrangement with the Gift of Life Foundation for the collection of bone marrow and peripheral blood stem cells for a period of one year beginning May 1, 2008.

Because last year's experience under the Arrangement was favorable, staff recommended that the Commission approve the Hospital's request, and that approval be contingent on the execution of the standard Memorandum of Understanding.

The Commission voted unanimously to approve staff's recommendation.

Union Hospital of Cecil County – 1979R

On May 2, 2008, Union Hospital of Cecil County submitted a full rate application requesting that its permanent rate structure increased by 3.41% effective June 1, 2008.

After review of the Hospital's application, staff recommended:

1. An overall rate increase of 2.6%, effective June 1, 2008, made up of an increase in inpatient charge per case of 4.61%, to $7,087 per case, and an increase to outpatient rates of 0.06%;
2. That the Uncompensated Care provision remain in rates for 12 months;
3. That the Hospital be exempt from the Commission's volume adjustment policy for volumes that occurred in FY 2008, and
4. That no additional allowance be made for case mix change.

The Commission voted unanimously to approve staff's recommendation.

Garrett County Memorial Hospital – 1981R

On May 6, 2008, Garrett County Memorial Hospital submitted a full rate application requesting an increase to its Total Patient Revenue (TPR) System permanent revenue of 6.16%.

Based on the HSCRC's ICC methodology, and allowing for adjustments deemed appropriate based on unique circumstances, staff recommended:

1. That the Hospital be allowed to remain on the TPR System;
2. That the Hospital's TPR Cap be set at $35,584,547;
3. That the increase in the CAP be effective June 4, 2008;
4. That the Hospital's rates continue to be adjusted as in the past; and
5. That future estimates of the Hospital's uncompensated care take into consideration the non-reimbursed portion of West Virginia Medicaid patient bills.

Hal Cohen, Ph.D., representing CareFirst and Kaiser Permantente, expressed approval of staff's recommendation and suggested that the Commission direct staff to help the Hospital in trying to get West Virginia Medicaid to pay more to Maryland hospitals.

The Commission voted unanimously to approve staff's recommendation.

Carroll Hospital Center – 1983R

On May 9, 2008, Carroll Hospital Center submitted an application requesting a rebundled rate, i.e. the rate to be charged to hospital inpatients for services provided by an off-site provider, for Radiation Therapy (RAT). The Hospital requested the state-wide median RAT rate be approved effective June 1, 2008.

After reviewing the Hospital's application, staff recommended:

1. That HSCRC's regulation, COMAR 10.37.10.07, requiring that application for a rate be made 60 days prior to the opening of anew service be waived;
2. That the current state-wide median RAT rate of $24.82 per RVU be approved as a rebundled rate effective June 1, 2008;
3. That no adjustment be made to the Hospital's current charge per case standard for the new RAT services; and
4. That the RAT rate not be rate realigned until a full year's cost experience has been reported to the Commission.

The Commission voted unanimously to approve staff's recommendation.

McCready Memorial Hospital – 1984N

On May 22, 2008, McCready Memorial Hospital filed a rate application requesting new rates for

Occupational Therapy (OTH) and Speech Therapy (STH) services. The Hospital asked that the state-wide median rates for both services be approved effective July 1, 2008

After review of the application, staff recommended:

1. That HSCRC's regulation, COMAR 10.37.10.07, requiring that application for a rate be made 60 days prior to the opening of a new service be waived;
2. That the OTH and STH rates of $5.92 and $6.59 per RVU respectively be approved effective July 1, 2008;
3. That no change be made to the Hospital's Charge per Case standard for the new OTH and STH services; and
4. That the OTH and STH rates not be rate realigned until a full year's cost data have been reported to the Commission.

The Commission voted unanimously to approve staff's recommendation.

Extensions

Staff requested a 30 day extension of time for review of the application of Dorchester General Hospital, proceeding 1982N.

The Commission voted unanimously to approve staff's request.

ITEM V
FINAL RECOMMENDATION ON THE QUALITY-BASED REIMBURSEMENT PROJECT BASED ON DELIBERATIONS OF THE INITIATION WORK GROUP

Robert Murray summarized the final recommendation on the Quality-Based Reimbursement Project. Mr. Murray noted that while the Project parallels Medicare's proposed pay for performance initiative in structure and timing, it is anticipated that eventually it will be much broader in scope given the comprehensive nature of the All-Payer System. Although, the Project is starting with process measures, there is an urgent need to move deliberately and carefully to the incorporation of outcome measures.

The recommendations focused on three areas: 1) the performance model; 2) the payment model; and 3) the data that will be used. The performance model utilizes the 19 process measures and evaluated hospitals on a ranking basis using both a reward and an incentive structure. Mr. Murray stated that the primary features of the payment model are: 1) little money at risk; 2) small number of services (approximately 15% of hospital discharges and 30% of hospital revenue); and 3) essential reporting of hospital performance on the measures. Data from CY 2007 will be used as the base period; CY 2008 will be the performance period; and rewards and incentive payments are to be made part of the FY 2010 update factor.

Mr. Murray thanked Commissioner Hall for chairing the Project, as well as: staff members Steve Ports, Dianne Feeney, Marva Tan; consultants Grant Ritter, Ph.D. and Vahe Kazandjian, Ph.D.; MHA and payer representatives; Don Hillier, former Commission Chairman; and the members of the Steering Committee, the IWG, and Subcommittee for their work on the project.

Ing-Jye Cheng, Assistant Vice President-MHA, and Barbara Epke, Senior Vice President-LifeBridge Health, recognized the excellent process associated with this initiative and expressed the support of the industry for: 1) the use of evidence-based quality measures, 2) the use of the "opportunity model" to calculate the scores, and 3) comparing hospital performance against benchmarks and for providing financial incentives for both quality attainment and improvement.

Dr. Cohen expressed the support of CareFirst and Kaiser Permanente for staff's recommendation.

The Commission voted unanimously to approve staff's recommendation.

ITEM VI
FINAL RECOMMENDATIONS REGARDING FUNDING FOR THE MARYLAND PATIENT SAFETY CENTER

Mr. Murray summarized the recommendation regarding funding of the Maryland Patient Safety Center (MPSC). The MPSC was established as one strategy for improving patient safety. Mr. Murray stated that pursuant to recommendations adopted by the Commission in 2004, the MPSC has been supported, in part, by the All-Payer system. The Commission has agreed to provide seed funding in the amount of 50% of the reasonable costs of the Center, less ½ of any carry-over from the previous year. Part of the reason for the Commission's support for the MPSC is the potential for improved outcomes, which result in cost savings to the system. Mr. Murray noted that the MPSC has been recognized nationally as doing an excellent job.

Therefore, staff recommended: 1) that the All-Payer system continue to be a partner with the MPSC; 2) that the MPSC continue to update the Commission on outcomes and estimated savings as a result of its programs; 3) that the MPSC aggressively pursue other sources of funding going forward; and 4) that the Commission reaffirm last year's recommendation to continue seed funding through the All-Payer system for FY 2009 in the amount of $1.9 million.

Bill Minogue, Executive Director of MPSC, detailed the steps that the MPSC has taken to become more self sufficient and expressed appreciation for the Commission's seed funding.

Chris Jensen, M.D., and Vahe Kazandjian, Ph.D., Board members of MPSC, reviewed the accomplishments of the MPSC and thanked the Commission not only for its financial support, but also for its moral support.

Mr. Minogue observed that the MPSC is really the convener; it only has two employees, and the hospitals have done the work.

Cal Pierson stated that although the Commission's funding support was appreciated, MHA hospitals and the Delmarva Foundation should increase their contributions in the future. Mr. Pierson urged the Commission, however, not to think of the All-Payer system funding as simply seed money that will eventually go away, but as a modest amount to pay for amount of good that it produces.

The Commission voted unanimously to approve staff's recommendation.

ITEM VII
FINAL RECOMMENDATION ON THE OUTPATIENT PAYMENT SYSTEM

John O'Brien, Deputy Director-Research and Methodology, summarized the final recommendation for the expanded outpatient charge-per-visit (CPV) payment system. Mr. O'Brien reported that since the draft recommendation was presented at the May public meeting, the outpatient work group met twice to review the recommendation. As a result, the final recommendation reflects two changes from the draft recommendation: 1) an exclusion concerning certain forms of therapy services; and 2) a second set of exclusions that will eliminate certain radiology procedures if they are the only significant APG within the visit. The adjustments reduce the revenue under the outpatient constraint system from 62% to approximately 50% of total outpatient revenue. However, the revenue constrained is double the revenue that was constrained under the ambulatory surgery system approved last year.

Graham Atkinson, Ph.D., Commission consultant, stated that the only other item that is new in the recommendation is that staff is suggesting that there should be an outlier provision, which is Appendix C of the recommendation. There will be discussions within the work group about the precise details of the provision.

Jacqui Howard, Director of Reimbursement of the University of Maryland Medical System, Kim Repac, Senior Vice President & CFO of the Western Maryland Health System, and Robert Vovak, Senior Vice President &CFO of the MHA, presented MHA's recommendations on the Outpatient Charge-per-Visit system.

Mr. Vovak noted that since there were no risk corridors in staff's recommendation, he would like the issue be re-visited at a later date.

Mr. O'Brien stated that the previous year's recommendation included the option of risk corridors considered. The reason for the risk corridors was that there was incomplete outpatient data being reported to the Commission, and the new APG grouper was not available. Now that both issues have been resolved, staff believes that the rationale for risk corridors is no longer there.

Mr. Vovak stated that MHA was approximately 95% in agreement with staff's recommendation. However, there are certain changes that MHA suggests should be made to the recommendation. One is that risk corridors should be approved because of the vast degree of bundling in the system. In many cases, there is only one APG assigned to a visit. Mr. Vovak noted that MHA may come back to the Commission if data analysis indicated that the 0.5% intensity factor is not sufficient.

Ms. Howard asserted that it is MHA's position that medical visits in the clinic should be excluded from the system for one year, because the explanatory power for those types of cases in the current methodology is too low compared to emergency department cases and other significant procedure cases. In addition, there is a large variation in charges within the clinic, associated with pharmaceuticals and expensive ancillary services, which MHA believes are not handled appropriately in the current methodology. MHA proposes that clinic cases be excluded so that additional analysis can be done to develop a more robust methodology to be implemented in FY 2010. Ms. Howard also expressed support for the development of an outlier policy.

Mr. Murray stated that the outlier policy will help explain some of the variations in the in the explanatory power, the R-square will increase and give a more robust correlation.

Ms. Repac stated that although we have resolved the big issues, the Commission should strive to have all outstanding issues resolved within 60 days. Ms. Repac reiterated that MHA supports the implementation of the CPV system July 1, 2008 with the caveats that: 1) medical clinic visits be excluded for one year; 2) that risk corridors be implemented for the first year of the system; and 3) that the intensity factor be re-visited in 2010.

The Chairman inquired whether MHA expects to get better than 25% R-square over time since medical visits are by nature quite variable.

Ms. Repac stated if a higher R-square is not achieved, then the outlier policy may have to be used to explain the variances.

Dr. Atkinson stated that the one or two $45,000 cases convinced staff that an outlier policy was needed. In addition, because of very high drug costs, staff decided that infusion therapy cases should be excluded. Dr. Atkinson noted that he did not expect a dramatic improvement in the R-square when the outlier policy is implemented; however, since the CPV system uses a hospital specific base, unless there is a dramatic change in the nature of cases within a hospital, there should be no great risk. Dr. Atkinson observed that the reason for the relatively low R-square in clinic visits is that the nature of clinics varies substantially among hospitals, but we do not expect so much variation within hospitals; therefore, staff feels comfortable in recommending going forward at this time.

Mr. O'Brien stated that the more accurate comparison is not that the 25% R-square is too low, but that the other R-squares are so high.

Ms. Repac and Mr. Vovak again requested that the Commission approve a 2% risk corridor

because the data have not been fully analyzed.

Commissioner Sexton asked Mr. O'Brien whether there was any new information since the draft recommendation was presented which made staff change its position on risk corridors.

Mr. O'Brien stated that as staff has seen the explanatory powers, the stability of the cases and the fact that we have excluded some problematic cases, which eliminated 10% of the outpatient revenue, staff is comfortable with the methodology and felt no need for corridors.

Commissioner Sexton asked staff what they felt was the downsides of having risk corridors.

Dr. Atkinson pointed out that there were two major downsides to risk corridors: 1) they greatly complicate the ability to monitor compliance because of the need to distinguish between the revenue under CPV compliance and the revenue under unit rate compliance; and 2) it "waters down" the incentives embodied in the system because there is no risk beyond the corridors, and the main purpose of the system is to provide strong incentives on utilization.

Mr. Murray suggested we let the system move forward and if significant issues arise, as with other issues in the past, staff will respond accordingly. Therefore, staff believes it would not be appropriate to impose corridors.

Dr. Cohen urged the Commission to approve staff's recommendation as proposed. Dr. Cohen noted that the payers are not happy that the CPV covers only 50% of outpatient revenue rather than the 62% initially anticipated. According to Dr. Cohen, the reduction in revenue covered under the CPV adds $7.5 million in pass-through revenue to the system. Dr. Cohen noted that corridors would take away the value of the trade-off that MHA made to reduce the intensity factor from 1% to 0.5% and move the 0.5% to the update factor.

Dr. Cohen asserted that it is important to remember that the CPV is a hospital specific proposal. The CPV compares a hospital to itself. That is why it is not necessary to have an Indirect Medical Education (IME) adjustment as you would have to do if you were comparing across hospitals, because a hospital either has IME or it does not. Dr. Cohen also expressed support for an outlier policy.

John Folkemer, Deputy Secretary for Health Care Finance and Medicaid Director for the Department of Health and Mental Hygiene (DHMH), expressed strong support for staff's recommendation and urged the Commission to adopt the CPV as recommended. Mr. Folkemer observed that introducing a reasonable constraint system into the outpatient system is long over due. Mr. Folkemer noted Medicaid has a disproportionate share of outpatient business, i.e., Medicaid has 15% of all emergency room visits and 25% of all clinic visits. Therefore, anything that the Commission does to affect the clinics is of great concern to Medicaid.

Mr. Folkemer pointed out that it is much better to have a system-wide, well thought out, rational, reasonable, measured approach such as the CPV system than having a single payer take a more drastic cost cutting measure, as has been done in the past. Mr. Folkemer urged the Commission

not to further erode the CPV system recommended by staff. Although the CPV system may not be as comprehensive as Medicaid would like, it is a sound, smart first step.

Commissioner Sexton asked whether risk corridors had a dollar cost.

Dr. Cohen stated anything that changes incentives has a dollar cost.

Commissioner Hall asked how outliers were chosen.

Dr. Atkinson stated that the technical work group first looked at visits likely to be serially billed because hospitals may submit a single record for multiple visits that are serially billed, e.g., chemo-therapy, radiation therapy, dialysis, and infusion-therapy. Also, large variations were observed in charges largely due to variations in drug costs in chemotherapy and infusion therapy. As a result these cases were excluded for this year; however, staff is planning to continue to work on them for inclusion in the future.

The Commission voted unanimously to approve staff's recommendation

ITEM VIII
DRAFT RECOMMENDATIONS ON THE FINANCIAL CONDITIONS REPORT

Mr. Murray summarized the draft recommendations on the Financial Conditions Report. Mr. Murray pointed out that the Commission is directed to keep informed as to whether a facility has enough resources to meet its financial requirements, and in an attempt to fulfill this responsibility, the Commission has periodically reviewed and issued a report on the financial condition of the Maryland hospital industry. Mr. Murray stated that the first report, issued in1989, established a series of operating, financing, and balance sheet indicators and desired target levels to be monitored year to year. These indicators and targets were revised in 1995 and in 2002. The purpose of these targets and indicators was to help the Commission evaluate over time the financial condition of the hospital industry.

Mr. Murray stated that the proposed report follows the format of analysis and discussion found in the 2002 Financial Conditions Review. The process focused on gathering information from financial experts in several areas: 1) access to capital, i.e., how are hospitals evaluated for credit by bond rating agencies, institutional investors, and bond insurers, and how are Maryland hospitals viewed because of the uniqueness of the rate setting system, both pro and con; 2) the current credit environment and the prospects for the future; and 3) hospital productivity.

Mr. Murray stated that in order to strengthen the meaningfulness of the report, staff recommended the following changes: 1) adding the Earnings Before Interest, Depreciation, Taxes, and Amortization (EBIDTA) ratio to measure the ability to generate cash; 2) including Cash on Hand and Debt to Capitalization ratios as reported to bond holders and lenders for the "Obligated Group" to ascertain the true strength of balance sheets utilized by a hospital when accessing the capital markets; and 3) moving from a range to a fixed target on Cost per

Equivalent Admission (EIPA).

Mr. Murray presented the recommended indicators and target levels, including the changes as: 1) Operating Margin Target 2.75%; 2) Excess Margin Target 4.0%; 3) Average Age of Plant 8.0 years; 4) Debt to Capitalization 0.40; 5) Cash Target 115 days-utilizing obligated group data; 6) Efficiency Target – Cost per EIPA 3.0% to 6.0% below the nation (pending results of ongoing analysis of EIPA calculation); 7) EBIDTA ratio target 10.75%; and 8) Debt Service Coverage ratio target 3.0.

A panel consisting of Stuart Erdman, Senior Director-Finance of the Johns Hopkins Health System, Ray Grahe, Vice President-Finance of the Washington County Health System, and Paul Sokolowski, Senior Vice President-Finance of MHA, presented the industry's comments on the proposed Financial Conditions Report.

Mr. Sokolowski stated that the industry and staff differ in how we should approach a Financial Conditions study. The industry believes that the report should: 1) assess the current health of the industry; 2) address the steps necessary to reach a desired result; and 3) set targets to address where the industry wants to be after some period of time. How the industry achieves the targets is a function of rate increases, productivity, and expenses control. According to Mr. Sokolowski, we must focus on trying to come to agreement on the targets.

Mr. Grahe stated that we have just seen in the last year, a major correction in the credit market that will be with us for a long time. Mr. Grahe observed that the auction market is dead, and that bond insurance is no longer an option to provide a higher credit rating. The market is returning to traditional credit spreads and is looking harder at the underlying credit of the facility. Therefore, it is very important that hospitals continue to perform financially at a high level, and that their underlying credit remains strong. Because of the market turmoil, bond ratings will be lower and the cost of capital will be higher.

Mr. Erdman stated that the targets are important in two ways; 1) what is the value of the target, i.e., is it what the market would expect Maryland hospitals to be attempting to attain in terms of profitability, cash, debt levels, etc.; and 2) how hospitals are performing against the targets. The targets should reflect what the industry should strive for after the completion of recapitalization. Mr. Erdman noted that to achieve the underlying credit position that industry believes it is necessary that all the targets be met because the targets are interrelated. We must all work together to agree on reasonable targets and develop a plan that can be taken to the capital market showing how hospitals can be expected to reach those goals.

Dr. Cohen commended staff on their work on the report. Dr. Cohen stated that it is important to remember that the bond rating operations relate to 5% to 10% of the nation's hospitals, and you have to be very careful in taking what is expected for these hospitals and applying that to 100% of Maryland hospitals. Dr. Cohen pointed out that targets should be set based on what they should be over the average life of the assets in the industry, not at what they should be in this period of huge re-capitalization.

Dr. Cohen noted that the payers believe the efficiency target to be extremely important. Dr.

Cohen asserted that the Commission should first determine where Maryland hospitals' cost should be in relation to the nation, then where profits should be relative to the nation, and, finally, derive the revenue target from these data. Dr. Cohen stated that the payers believe that the Commission should select a point that Maryland hospitals should be below the nation, and that point (recommended 5%) should dictate where the other targets should be.

ITEM IX
UNCOMPENSATED CARE POLICY RESULTS AND DRAFT RECOMMENDATION

Mr. Murray reminded the Commissioners that it is the Commission's duty along with DHMH to facilitate Medicaid expansion, as per Senate Bill 6 the Working Families and Small Business Health Coverage Act, passed by the General Assembly in the 2007 Special Session. The expansion is to be funded from savings from averted hospital uncompensated care (UCC) and matching federal funds. The HSCRC was to estimate the savings to be realized in averted UCC for each hospital individually, adjust each hospital's UCC in rates, and then assess an amount in each hospital's rates equal to a portion of the estimated savings to be remitted to the Health Care Coverage Fund. Any savings not subject to the assessment would be used to reduce hospital rates and provide savings to purchasers. During the 2008 session, legislation was enacted to revise the funding of the expansion. Senate Bill 974/House Bill 1587 repealed the averted bad debt assessment in Senate Bill 6 and replaced the hospital specific non-uniform assessment with a broad-based uniform provider tax, which would not only allow Medicaid to maximize federal matching funds, but also would: positively impact the Medicare waiver (because it lowers hospital rates); more equitably share the burden of UCC; and reduce Medicaid expenditures because it lowers rates of hospitals with higher proportions of Medicaid patients.

Mr. Murray reported that in addition to altering the funding of the health care expansion efforts, Senate Bill 974/House Bill 1587 made the Maryland Health Insurance Plan (MHIP) assessment more responsive to the current needs of the program. Regulations have been proposed to increase the assessment from 0.81% to 1.0% of net patient revenue. While the State budget eliminated Medicaid Day Limits on January 1, 2009, the Bill also allows an assessment in FY 2009 to recover the expected value of the Medicaid Day Limits savings to Medicaid for the period from July 1, 2008 to December 31, 2008. Thus, Medicaid Day Limits will be eliminated on July 1, 2008.

Mr. Murray pointed out that this is a draft recommendation. Staff will be working with the industry to review the assumptions and the methodology. Staff will present a final recommendation at the July public meeting.

Dr. Cohen stated that it was extremely important that the Commission maintain a fair and equitable financing of UCC. Dr. Cohen noted that CareFirst and Kaiser Permanente have always been strong supporters of financing UCC through the All-Payer system. They supported raising rates with the advent of Medicaid Day Limits and when the elimination of the Medicaid State Only program increased UCC. Now it is important that the Commission prospectively lower rates when it knows that Medicaid is being expanded. Dr. Cohen urged the Commission to

support staff's recommendation.

Ms. Cheng, representing MHA and David Krajewski, Vice President –Finance of LifeBridge Health and Chairman of MHA's Financial Technical Task Force (FTTF), presented the industry's comments on staff's proposal. Ms. Cheng stated that the industry was not aware that there would be a prospective adjustment to hospital's UCC provision for Medicaid expansion this year. However, the industry is willing to work with staff to make sure it is a reasonable and collaborative process. Ms. Cheng pointed out that the legislative language that authorized the Commission's action focuses on having the Commission make an adjustment based on "realized" savings from averted UCC. According to Ms. Cheng, the industry did not learn of the concept of the UCC adjustment being made prospectively until last Friday, May 30th. This morning was the first time that MHA has seen this detailed proposal, and the industry will have its first look at it at tomorrow's FTTF meeting. This is in stark contrast to the very collaborative process that we have had on a number of issues in the past.

Mr. Krajewski stated the industry has several points of concern: 1) how will this Medicaid program be rolled-out, i.e., registering recipients can take up to six months, so that the impact of the program in the first year in reducing bad debts may be negligible; 2) how can averted bad debts be reasonably estimated without a data base on these recipients; 3) there is no mechanism to track and measure the incremental volume increases associated with these recipients once they have insurance; and 4) how does the averted bad debt methodology interact with the UCC policy methodology. Mr. Krajewski suggested that we should take the time needed to sort through these issues and then estimate what the prospective impact would be on hospitals.

Ms. Cheng stated that there are two primary issues: 1) when people are going to enroll; and 2) when are they actually going to use care.

Mr. Murray stated that staff will try to be consistent in the implementation of this program, which makes a prospective adjustment for a decrease in UCC, as in prior instances when prospective adjustments were made for projected increases in UCC. Mr. Murray also noted that this is not the first time that the industry has heard staff's proposal. It was been discussed in the FTTF.

Mr. Sokolowski stated that the hospitals are not questioning the assessment; they are questioning the prospective adjustment to hospitals' UCC provision.

Dr. Cohen stated that it is extremely important that the Commission handle these adjustments as a package. Dr. Cohen noted that there are data bases upon which to make reasonable estimates, and there will be a settle-up.

ITEM X
DRAFT RECOMMENDATIONS ON INVASIVE RADIOLOGY-CARIOVASCULAR RELATIVE VALUE UNITS

Rodney Spangler, Chief – Audit & Compliance, requested approval to promulgate for review and comment a staff recommendation for revisions to the Relative Value Units associated with Radiology/Cardiovascular services.

The Commission voted unanimously to approve staff's request

ITEM XI
HEARING AND MEETING SCHEDULE

July 2, 2008	Time to be determined, 4160 Patterson Avenue, HSCRC Conference Room
August 6, 2008	Time to be determined, 4160 Patterson Avenue, HSCRC Conference Room

There being no further business, the meeting was adjourned at 12:03 p.m.