STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

John M. Colmers
Chairman

Joseph R. Antos, Ph.D.

George H. Bone, M.D.

Jack C. Keane

Bernadette C. Loftus, M.D

Thomas R. Mullen

Herbert S. Wong, Ph.D.

HEALTH SERVICES COST REVIEW COMMISSION
4160 Patterson Avenue, Baltimore, Maryland 21215
Phone: 410-764-2605 · Fax: 410-358-6217
Toll Free: 1-888-287-3229
www.hscrc.state.md.us

Stephen Ports
Acting Executive Director

Gerard J. Schmith
Deputy Director
Hospital Rate Setting

Mary Beth Pohl
Deputy Director
Research and Methodology

482nd MEETING OF THE HEALTH SERVICES COST REVIEW COMMISSION
October 12, 2011

EXECUTIVE SESSION
9:30 a.m.

1. **Personnel and Waiver Issues**

PUBLIC SESSION OF THE
HEALTH SERVICES COST REVIEW COMMISSION
10:00 A.M.

1. **Review of the Executive Session and Public Meeting Minutes of September 14, 2011 Meeting**

2. **Executive Director's Report**

3. **Docket Status – Cases Closed**

   2129A – Johns Hopkins Health System
   2130N – Suburban Hospital
   2132A – University of Maryland Medical Center
   2133A – MedStar Health
   2134A – MedStar Health
   2136A – University of Maryland Medical Center

4. **Docket Status – Cases Open**

   2128A – MedStar Health
   2131A – St Agnes Health Care, Maryland General Hospital, Meritus Health, and Western Maryland Health System
   2135A – Johns Hopkins Health System

5. **Options for Reconciliation of FY 2010 Averted Bad Debt Estimates to Actual**

6. **Final Recommendation on FY 2013 Scaling for Quality-based Reimbursement and Maryland Hospital Acquired Conditions Performance**

7. **Hearing and Meeting Schedule**

Executive Session Minutes
Of the
Health Services Cost Review Commission

September 14, 2011

Upon motion made, Chairman Colmers called the meeting to order at 9:31 a.m.

The meeting was held under the authority of Section 10-508 of the State-Government Article.

In attendance, in addition to Chairman Colmers, were Commissioners Bone, Keane, Mullen, and Wong.

Steve Ports, Jerry Schmith, and Dennis Phelps attended representing staff.

Joseph Hoffman, Senior Vice President and CFO, attended representing Upper Chesapeake Health System.

Also attending were Stan Lustman and Leslie Schulman Commission Counsel.

Item One

The Commissioners discussed personnel and waiver issues.

Item Two

The Commission heard from Joseph Hoffman, representative of the Upper Chesapeake Health System (UCHS), in its proposal to construct a Cancer Center to be physically connected to the Upper Chesapeake Medical Center (UCMC). The total cost of the project is approximately $62.5 million with $50 million to be financed and the balance paid for by equity contributions from UCMC, Harford Memorial Hospital, and the Upper Chesapeake Health Foundation.

After discussion, the Commission voted to approve the Comfort Order request of UCHS. Ratification of the vote to take place in the public session.

The Executive Session was adjourned at 10:14 a.m.

481ST MEETING OF THE
HEALTH SERVICES COST REVIEW COMMISSION

September 14, 2011

Chairman John Colmers called the meeting to order at 10:18 a.m. Commissioners George H. Bone, M.D., Jack C. Keane, Thomas R. Mullen, and Herbert S. Wong, Ph.D. were also present.

REPORT OF THE EXECUTIVE SESSION OF SEPTEMBER 14, 2011

Dennis Phelps, Associate Director-Audit & Compliance, summarized the minutes of the September 14, 2011 Executive Session.

COMFORT ORDER-UPPER CHESAPEAKE HEALTH SYSTEM

The Commission voted unanimously to ratify the Comfort Order for Upper Chesapeake Health System approved in Executive Session.

ITEM I
EXECUTIVE AND PUBLIC SESSIONS OF AUGUST 11, 2011

The Commission voted unanimously to approve the minutes of the August 11, 2011 Executive and Public Sessions.

ITEM II
EXECUTIVE DIRECTOR'S REPORT

Steve Ports, Acting Executive Director, advised the Commission of the progress on current major initiatives and issues. They include: 1) finalizing a letter to the Secretary of Health and Human Services requesting an exemption from CMS' Value Based Purchasing (VBP) quality program; 2) adoption of a change in methodology to utilize the statewide average for measuring hospitals' relative performance for scaling of the 1% Maryland Hospital Acquired Conditions (MHAC) initiative for FY 2012; 3) finalizing a recommendation to be presented at the October public meeting on the magnitude of MHAC scaling; 4) finalizing ARR agreements with twenty-five hospitals for FY 2012; 5) finalizing the ARR payment weights and developing an operating protocol manual; and 6) expecting the completion of rate orders in October.

Mr. Ports reported that staff is contemplating filing a letter of intent to participate in Model #1 of CMS's Bundled Payment for Care Initiative . Model #1 involves strategies for the coordination of care among health care providers for inpatient hospital care.

ITEM III
DOCKET STATUS CASES CLOSED

2114N – Adventist Behavioral Health
2116N – Germantown Emergency Center
2118N – Bowie Emergency Center
2124A – Johns Hopkins Health System
2126A – University of Maryland Medical Center
2127A – University of Maryland Medical Center

ITEM IV
DOCKET STATUS CASES OPEN

Suburban Hospital – 2130N

On August 8, 2011, Suburban Hospital submitted a partial rate application requesting a rate for Operating Room Clinic (ORC) services. The Hospital requested a rate based on its costs and volumes or the statewide median ORC rate.

After review, 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 an ORC rate of $12.51 per minute be approved effective September 1, 2011;
3. That no change be made to the Hospital's charge per visit standard for ORC services; and
4. That the ORC 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. Chairman Colmers recused himself from consideration of this application.

Johns Hopkins Health System – 2129A

Johns Hopkins Health System ("System") filed a renewal application with the HSCRC on August 3, 2011 on behalf of the Johns Hopkins Bayview Medical Center (the "Hospital") requesting approval from the HSCRC for continued participation in a capitation arrangement among the System, the Maryland Department of Health and Mental Hygiene (DHMH), and the Centers for Medicare and Medicaid Services (CMS). The Hospital, doing business as Hopkins Elder Plus ("HEP"), serves as a provider in the federal "Program of All-inclusive Care for the Elderly" ("PACE"). Under this program, HEP provides services for a Medicare and Medicaid dually eligible population of frail elderly. The requested approval is for a period of one year effective September 1, 2011.

Staff found that the experience under this arrangement for FY 2011 was unfavorable. However,

based on the initiatives taken by HEP, staff recommended that the Commission: 1) waive the requirement that an application be filed 30 days prior to the effective date of an alternative rate determination arrangement; and 2) approve the Hospital's renewal application for an alternative method of rate determination for one year beginning September 1, 2011, and that the approval be contingent upon the execution of the standard Memorandum of Understanding.

The Commission voted unanimously to approve staff's recommendation. Chairman Colmers recused himself from consideration of this application.

University of Maryland Medical Center – 2132A

On August 22, 2011, the University of Maryland Medical Center filed an alternative method of rate determination application requesting approval to continue to participate in a global rate arrangement for solid organ and bone marrow transplant services with Maryland Physicians Care. The Hospital requested that the arrangement be approved for a period of one year beginning August 23, 2011.

Staff found that the experience under the arrangement for last year was favorable.

Therefore, staff recommended that the Commission: 1) waive the requirement that alternative rate applications be filed 30 days before the proposed effective date; 2) approve the Hospital's request for a period of one year effective August 23, 2011, and 3) 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 – 2133A

On August 22, 2011, MedStar Health filed an alternative method of rate determination application on behalf of Union Memorial Hospital and Good Samaritan Hospital requesting approval to continue to participate in a global rate arrangement for cardiovascular services with the Kaiser Foundation Health Plan of the Mid-Atlantic, Inc. for one year beginning October 1, 2011.

Staff reviewed the experience under this arrangement for the last year and found it to be favorable.

Therefore, staff recommended that the Commission approve the Hospitals' request for a period of one year effective October 1, 2011, 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 – 2134A

On August 22, 2011, MedStar Health filed an alternative method of rate determination application on behalf of Union Memorial Hospital and Good Samaritan Hospital requesting approval to continue to participate in a global rate arrangement for orthopedic services with MAMSI for one year beginning September 1, 2011.

Staff reviewed the experience under this arrangement for the last year and found it to be favorable.

Therefore, staff recommended that the Commission approve the Hospitals' request for a period of one year effective September 1, 2011, and that the approval be contingent upon the execution of the standard Memorandum of Understanding.

The Commission voted unanimously to approve staff's recommendation.

University of Maryland Medical Center – 2136A

On August 30, 2011, the University of Maryland Medical Center filed an alternative method of rate determination application requesting approval to continue to participate in a global rate arrangement for liver and blood and bone marrow transplant services with Cigna Health Corporation for one year beginning July 1, 2011.

Staff found that the experience under this arrangement for the past year was favorable. Therefore, staff recommended that the Commission: 1) waive the requirement that alternative rate applications be filed 30 days before the proposed effective date; 2) approve the Hospital's request for a period of one year effective July 1, 2011, and 3) that the approval be contingent upon the execution of the standard Memorandum of Understanding.
The Commission voted unanimously to approve staff's recommendation.

Medicaid Health Choice Program

Mr. Ports summarized staff's draft recommendations for the applications of: MedStar Health System on behalf of MedStar Family Choice; Maryland General Hospital, St. Agnes Health System, Western Maryland Health System, and Meritus Health on behalf of Maryland Physicians Care; and Johns Hopkins Health System on behalf of Priority Partners, Inc. for continued participation in the Medicaid Health Choice Program for one year beginning January 1, 2012.

Mr. Ports announced that the final recommendations will be presented at the October 12, 2011 public meeting.

ITEM V
FINAL RECOMMENDATION ON RESIDUAL OUTLIER POLICY FOR UPDATE FACTOR SCALING BASED ON REASONABLENESS OF CHARGES (ROC) REPORT BEGINNING IN FY 2013

Andy Udum, Associate Director-Research and Methodology, presented the final recommendations on the treatment of outliers in the Reasonableness of Charges (ROC) regression analysis.

The final staff recommendations are to adopt as policy the method used to handle outliers in the FY 2012 ROC regression. This method is: 1) to routinely conduct regression diagnostics on preliminary ROC regression results; 2) when warranted, to remove the significant outliers, and 3) to apply the coefficients to all hospitals including the hospitals removed as outliers.

The Commission voted unanimously to approve staff's recommendation.

ITEM VI
OPTIONS FOR RECONCILIATION OF FY 2010 AVERTED BAD DEBT ESTIMATES TO ACTUAL

Mr. Ports presented an overview and history of Medicaid expansion, the Averted Bad Debt (ABD) Policy, and options for reconciliation of the FY 2010 estimates to actual (see staff Options for Reconciliation of FY 2010 Bad Debt Estimates to Actual on the HSCRC website). Mr. Ports reported that staff calculated that the actual reduction in uncompensated care (UCC) associated with Medicaid expansion of coverage was less than the estimated averted bad debt resulting in hospitals remitting $25.5 million more to Medicaid than the amount of hospital UCC actually reduced.

Mr. Ports presented staff proposed options for handling the overpayment to Medicaid. The first option is to reduce future assessment payments to Medicaid, i.e., hospitals would remit to Medicaid $25.5 million less than the uniform assessment included in rates. This would result in increasing Medicaid's budget deficit in the year that the assessment payment is reduced. The second option is to increase hospital rates in FY 2012 to reflect the overpayment above the estimated averted bad debt assessment. This would make hospitals whole, but payers would have paid the assessment twice. The third option is to reduce or eliminate the savings intended to accrue to payers as a result of the averted bad debt derived from Medicaid expansion. This option would reduce the overpayment by approximately $5 million, the amount contemplated as savings during the legislative process that created the averted bad debt assessment. The fourth option is to take no action. Under this option, hospitals would not be permitted to recover any of the FY 2010 overpayment. The overpayments negatively impacted hospital profits in FY 2010. The fifth option would be to adopt a combination of options one through four.

The Chairman noted that this was an opportunity for the Commission to hear from the various parties about the issues, and that no action would be taken today.

Commissioner Mullen inquired as to whether any hospitals were overburdened by the averted bad debt shortfall.

Jerry Schmith, Deputy Director-Hospital Rate Setting, stated that the impact varied by hospital. Some hospitals were more adversely affected than others.

A panel consisting of Joshua M. Sharfstein, M.D., Secretary of the Department of Health and Mental Hygiene (the "Department), Charles J. Milligan, Jr., Deputy Secretary-HealthCare Finance, and Trisha Roddy, Director of Planning for the Medicaid Program, presented comments.

Secretary Sharfstein stated that it was the Department's position that staff's paper, "Options for Reconciliation of FY 2010 Avert Bad Debt Estimates to Actual," does not provide an adequate basis for decision-making and was pleased that the Commission had decided to defer action and spend some more time on the issues raised.

According to the Secretary, there are several major issues not addressed in staff's paper and, as a result, does not offer the kind of options the Commission needs to make a reasonable decision. Specifically the Department has raised some very important concerns that have not been addressed. The paper does respond to the Department's assertion that actual data indicate that the 28% crowd out assumption utilized in the averted bad debt calculation is not borne out by experience. The Department believes that 28% is the wrong number and, therefore, the Medicaid overpayment of $25 million is the wrong number.

The Secretary also stated that there is actual experience showing that the Use Rate assumption used in the ABD calculation, that people will annually use 18% more hospital services when they are insured, is not correct. Evidence from the Medicaid expansion population indicates that the Use Rate is not a fixed rate and that it goes down over time. The Department believes that an adjustment should be made to the ABD calculation to reflect the actual adverted bad debt. At a minimum, staff should look at the Department's data and analysis and take that all into consideration when proposing options to the Commission.

In addition, according to the Secretary, staff's paper fails to adjust the ABD calculation's crowd out assumption to reflect the impact of people losing their health insurance because of the recession.

Secretary Sharfstein stated the Commission should give serious consideration to these issues.

Commissioner Wong asked what staff's reaction was to the Department's assertions concerning the crowd out and use rate components of the ABD calculation.

Mr. Ports stated that staff has heard these assertions, as well as opinions on the other side of the issues. Based on everything presented thus far, staff sees no reason to alter the 28% crowd out number. However, staff is willing to listen and would like to see the information that the Department and the hospital industry have to offer.

Mr. Schmith added that as of this date, staff has not received credible data one way or the other to prove that there is a better crowd out number.

Commissioner Bone asked where the data that the Department is referring to came from.

Ms. Roddy replied that it was a sample of data from 25 hospitals, which indicated that the crowd out percentage was about 10%. In addition, the Department has actual use rate data.

Traci LaValle, Assistant Vice President-Financial Policy of the Maryland Hospital Association (MHA), stated that the effect of the ABD over payment caused cash flow problems in smaller hospitals in particular. The hospital industry believes that it is important to use the same assumptions in the ABD calculation when you do the estimates at the beginning of the period as when you do the reconciliation at the end of the period.

Ms. LaValle noted that the literature on crowd out is not consistent. It ranges from 0% to 60%. The percentage utilized, 28%, was provided by Medicaid as a reasonable estimate of crowd out.

Ms. LaValle stated that the 25 hospital sample data referred to by the Department was complied by MHA. The data showed that of a sample of 2009 Medicaid expansion patients with admissions at the same hospital in 2008, 11% had been covered by private insurance and 45% were covered by Medicaid or MCOs. The dispute is over how you define crowd out. The definition that Medicaid wants to use is the one typically found in the literature and in public policy discussions - - i.e., how much private coverage is displaced. MHA, on the other hand, believes that the definition should be a little different in the context of the ABD program. Since we are not making a public policy decision as to whether or not to institute a program (the ABD program is already in place), the definition of crowd out should be how much of the care provided under the new coverage is actually ABD. Therefore, crowd out should include people who were previously covered by Medicaid.

The Chairman asked which option MHA favors.

Ms. LaValle stated that MHA favors Option #1, reducing future assessments.

Barry Rosen, representing United Healthcare, expressed support for Option #1. Mr. Rosen asserted that options 2, 3, and 5 are inappropriate because they all increase hospital rates. By increasing rates the options: 1) result in payers paying twice for an assessment that is too high; 2) make hospital care more unaffordable; and 3) cause problems with the all-payer provision of the Medicare waiver because the payments could be construed as a discount to Medicaid.

According to Mr. Rosen, HSCRC law states that it is the HSCRC's responsibility to ensure that the Medicaid Expansion assessment on hospitals does not exceed the actual savings to Medicaid resulting from expansion. Therefore, if the assessment was too high, legally, Option #1 is the HSCRC's only choice.

Mr. Rosen also stated that Chairman Colmers in his former capacity as Secretary of Health,

wrote a 2009 letter to the Chairmen of the State Budget and Taxation Committee and the House Appropriations Committee stating that what was wrong with the original assessment was that it was hospital specific, non-uniform, and retrospective. What he asked the legislature to do was to change it to a broad based, uniform, and prospective assessment. Mr. Rosen asserted that Options 2, 3, and 5 are retrospective. Chairman Colmers asked Mr. Rosen to provide the full context of his letter.

The Chairman asked whether the payers would participate in discussions on the crowd out and use rate issues.

Mr. Rosen indicated his willingness to participate in such discussions.

Hal Cohen, Ph.D., representing CareFirst and Kaiser Permanente, participating by telephone, expressed support for Option #1.

Commissioner Bone asked Mr. Rosen how the resumption of Medicaid Day Limits would affect hospital UCC.

Mr. Rosen stated that UCC would increase.

Commissioner Bone asked whether Medicaid Day Limits or the ABD assessment result in greater cost to the system.

Mr. Rosen responded that the appropriate approach is to ensure that this assessment is not greater than the savings; settle-up with the hospitals; and, then, if there is another Medicaid budget deficit to discuss, decide what the best method is to deal with it.

ITEM VII
SUMMARY OF THE FY 2010 DISCLOSURE OF FINANCIAL AND STATISTICAL DATA

Dennis N. Phelps, Associate Director-Audit & Compliance, summarized the annual disclosure of financial and statistical data for Maryland hospitals. Mr. Phelps announced that for the first time in the history of the HSCRC hospital admissions declined from the previous year (from 703,323 in FY 2009 to 693,284 in FY 2010 or 1.4%). Other major highlights of the report were: 1) patients at Maryland hospitals paid on average 2% more in FY 2010 than in 2009, while the amount paid nationally was estimated to have risen by 3%; 2) the cost per admission in Maryland hospitals increased by 1.6% in FY 2010; 3) from FY 1977 through 2009, Maryland experienced the lowest growth in cost per admission of any state in the nation; 4) profits on regulated activities increased from $669 million in FY 2009 to $715 million in FY 2010; 5) profits on all operations, both regulated and unregulated, were up from $319 million in FY 2009 to $328 million in FY 20010; 6) Maryland hospital total profits increased substantially in FY 2010 from $2 million or 0.01% to $481 million or 0.3.8%; and 7) Maryland hospitals provided more than $926 million of uncompensated care in FY 2010.

Mr. Phelps noted that Maryland hospitals did a good job in FY 2010 of controlling expenses while increasing profits on regulated services. However, costs associated with unregulated physician services continued to be a significant problem for many hospitals.

ITEM VIII
HEARING AND MEETING SCHEDULE

October 12, 2011	Time to be determined, 4160 Patterson Avenue, HSCRC Conference Room
November 2, 2011	Time to be determined, 4160 Patterson Avenue, HSCRC Conference Room

There being no further business, the meeting was adjourned at 11:47 a.m.

Executive Director's Report **October 12, 2011**

Current and Future Projects	Status/Timing
1. Quality-based Reimbursement (QBR) and Maryland Hospital Acquired Conditions (MHAC)	
- Letter to request exemption/certification from Secretary Of HHS that QBR/MHAC "meets or exceeds" national VBP	Complete
- Recommend magnitude of scaling for FY 2013	October meeting
2. Admission Readmission Revenue Proposals	
- Close to signing 26 proposals	October
- Signing Deadline	October
3. Rate Orders	
- Weights	
o CPC	Complete
o CPV	Complete
o ARR	October/Nov.
- Case Mix	
o Inpatient	Complete
o Outpatient	Complete
o ARR CMI	October/Nov.
- UCC Calculation	October/Nov.
4. CMS Bundled Payments for Care Improvement Initiative	
- Model 1	
o Letter of Intent	Complete
o Applications	November 18
- Models 2 and 4	
o Letter of Intent	November 4
o Applications	March 15
5. Medicaid Provider-based MCO ARMs	November Meeting

Options for Reconciliation of FY 2010 Averted Bad Debt Estimates to Actual

Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215
410-764-2605

October 12, 2011

The final recommendation approved by the Commission at the October 12, 2011 Public Commission Meeting is Option 1 to be applied in one year, a reduced hospital assessment of $10.9M for FY 2012.

Purpose

The purpose of the this paper is to illustrate how the Health Services Cost Review Commission (the Commission or HSCRC) estimates hospital averted bad debt resulting from the Medicaid expansion; to show how the Commission determines the actual amount of averted bad debt in that year; and to propose a series of options for the Commission to consider for reconciling estimates to the actual results.

Following the September Commission meeting, HSCRC staff further engaged in discussions with the Department of Health and Mental Hygiene (the Department), hospital, and payer representatives to discuss averted bad debt for state fiscal year (FY) 2010. Our process included discussions with the individual parties, independent literature research, review of research provided by the Department, and the facilitation of two in-person meetings among the interested parties. Our efforts focused on two areas:

1. Review the crowd out rate and lower use rate adjustment factors; and, calculate the resulting "actual" averted bad debt.
    - Recommendation: Based on our review, HSCRC staff recommends lowering the crowd out rate in the averted bad debt calculation from 28 percent to 18.22 percent.
    - Recommendation: Based on our review, HSCRC staff recommends maintaining the lower use rate at 18 percent. While Department staff make a logical argument toward reducing the lower use rate, the supporting data did not provide HSCRC staff a reduction amount to apply to our calculations. We suggest that the Department continue to refine data extracts to better quantify the most appropriate lower use rate for upcoming years.
    - Recommendation: Based on our discussions with the payers, HSCRC staff recognized an error in our including savings to the payers as a component of calculating the actual averted bad debt. We have removed this component from our calculations.

    Based on the above three recommendations, the difference between the amount paid by hospitals to the Department and the calculated aggregate actual averted bad debt is **$10.9 million**.

2. Determine the most appropriate means of reconciling the difference between the amount paid by the hospitals to the Department and actual averted bad debt.
    - Commission staff is seeking guidance from the Commission on the best means to reconcile the estimated averted bad debt to actual for FY 2010. We provide potential reconciliation options in the final section of this paper.

Background

In 2007, the General Assembly enacted Chapter 7 of the Laws of Maryland, The Working Families and Small Business Health Coverage Act (The 2007 Act), which expands access to health care in the following ways:

- Expands Medicaid eligibility to parents and caretaker relatives with household income up to 116 percent of the federal poverty guidelines (FPG), an increase from 46 percent FPG, to be implemented beginning in FY 2009;

- Contingent on available funding, incrementally expands the Primary Adult Care (PAC) program benefits over three years to childless adults with household income up to 116 percent FPG (previously 46 percent FPG), to be phased in from FY 2010 through FY 2013; and

- Establishes a Small Employer Health Insurance Premium Subsidy Program, to be administered by the Maryland Health Care Commission.

Special funds, including savings from averted uncompensated care and federal matching funds, will cover a portion of the costs of the expansion. Chapters 244/245 of the Laws of Maryland were adopted in 2008 to require the Commission to implement a uniform assessment on hospital rates that reflects the aggregate reduction in hospital uncompensated care realized from the expansion of the Medicaid Program under The 2007 Act. To qualify for federal matching funds, Chapters 244/245 require the assessment to be broad-based, prospective, and uniform.[1] The 2008 legislation also requires the Commission to ensure that the assessment amount does not exceed the savings realized in averted uncompensated care from the health coverage expansion.

In conformance with The 2007 Act, Medicaid enrolled approximately 29,273 expansion population individuals in FY 2009. In FY 2010, expected enrollment in the Medicaid expansion grew to 50,500.

As described above, The 2007 Act also expands services to childless adults, contingent on available funding. Prior implementation of this provision, the childless adult population received only primary care, pharmacy, and certain office and clinic-based mental health services through the PAC program. The Act intended to phase in specialty physician, emergency, and hospital services over a three-year period, to the extent that available funding exists. In accordance with Board of Public Works action in July of 2009, Medicaid added emergency services to the PAC benefit beginning January 1, 2010.

[1] The federal Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 require that in order for provider taxes to access federal matching funds, they may not exceed 25 percent of a state's share of Medicaid expenditures; they must be broad-based and uniform; and they may not hold providers harmless. A uniform tax is one that is imposed at the same rate on all providers.

Hospital Uncompensated Care

Hospital Uncompensated Care (UCC) provisions in Maryland hospital rates are specific to each hospital and based on formulas and historical data. Thus, the amount a hospital receives in its rate base varies year by year based on the Commission's UCC policy and formula. Commission staff calculate and release the UCC policy results every year, usually in May or June. The prospective amount established for each hospital for the upcoming year is a blend of a hospital's three year average actual UCC and a predicted amount calculated by means of a linear regression model. In a final UCC calculation step, Commission staff applies a revenue neutrality adjustment to adjust each hospital's calculated UCC percentage to align with the last year's statewide average UCC percentage. See Table 1 for an example of the UCC policy calculation.

Table 1: Example of the HSCRC's Uncompensated Care Policy with Results

Policy Steps		**Example of FY 2008 UCC for a Hospital**	
Step 1	For each hospital, calculate the three year moving average of actual UCC	*Actual UCC* 2005: 6.25% 2006: 6.72% 2007: 7.15%	*Moving average* $\frac{(6.25\% + 6.72\% + 7.15\%)}{3} = 6.71\%$
Step 2	For each hospital, use a linear regression model to determine the predicted UCC	*Regression predicted UCC value for hospital:* 7.05%	
Step 3	50/50 blend the results from Step 1 and Step 2	*50/50 blend of past actual and regression prediction:* $(6.71\% + 7.05\%)/2 = 6.88\%$	
Step 4	Apply revenue neutrality adjustment to align each hospital with the most recent year's statewide actual UCC	*Statewide UCC 2007: 7.30%* *Statewide Step 3 blended (all hospitals): 7.15%* *Statewide revenue neutrality adjustment percentage:* $7.30\% / 7.15\% = 1.02\%$ *Hospital UCC adjusted for revenue neutrality:* $6.88\% * 1.02\% = 7.02\%$	
Result	**HSCRC applies the hospital-specific FY 2008 UCC policy result of 7.02% to FY 2009 rates for that hospital.**		

Because Commission staff calculate the policy result (UCC provision for each hospital) prospectively based partially on historical data, there is always a slight discrepancy (by design) between actual UCC experienced by hospitals and the UCC provision in rates per HSCRC policy. This lag, which stabilizes the UCC across time, also results in UCC being slightly underfunded when the actual number of uninsured is increasing over time, and UCC being overfunded when the actual number of uninsured is decreasing over time (e.g., during periods of economic prosperity, systematic changes to increase coverage such as small group health insurance reform or implementation of the Maryland Children's Health Insurance Program).

Determination of the Averted Bad Debt Assessment Amount

As discussed in the Background section above, Chapters 244/245 from 2008 require the Commission to implement a uniform assessment on hospital rates. The assessment is required to reflect the aggregate reduction in hospital uncompensated care that will be realized from the expansion of the Medicaid Program under The Act.

Beginning in FY 2009, each year, the Commission works with the Department to arrive at a total amount of bad debt that is expected to be averted during the upcoming fiscal year as a result of the Medicaid expansion. The Department provides the HSCRC with expected enrollment, per member/per month costs, and total expenditures. Commission staff then adjusts the expected total Medicaid expansion expenditure amount to reflect:

- Out-of-State Admissions – This represents the percentage of expenditures expected to be made at hospitals in Maryland. Using a three-year average from Medicaid claims data, the percentage applied to the estimated total Medicaid expansion expenditure is 94 percent;
- The Hospital Portion – This is the estimated percentage of Medicaid expansion expenditures that would accrue to hospitals (as opposed to other providers or service components). This percentage was calculated based on Medicaid HealthChoice reimbursement data which categorizes payment rates by hospital, drug, and other components;
- Crowd out – This estimates the share of Medicaid expansion spending that is directed to individuals who previously had private health care coverage. Based on available literature at the time, the Commission and the Department agreed to 28 percent as a reasonable crowd out adjustment for the FY 2010 prospective calculation of the assessment amount.
- Lower Use Rate - Literature indicates that uninsured enrollees tend to use hospital services at a lower rate than newly enrolled individuals. Individuals moving from having no insurance to having Medicaid coverage have a "pent up demand" that is evidenced by increased use of hospital services. Based on the literature review at the initiation of this policy, HSCRC and Department staff determined that 82 percent is a reasonable estimate for a lower use rate.

The product of this calculation results in a total amount that is differentially removed from the uncompensated care amounts across all hospitals for that year. The amount removed for each hospital is based on the proportion of Medicaid's expenditures for this type of population at each hospital. In FY 2009, HSCRC staff used Medicaid claims and encounter data for specific Medicaid populations by hospital as proxy for the expansion experience.

Since the assessment is required to be uniform and broad-based, the Commission adds back to the rates of all hospitals an equal percentage that represents the total estimated averted bad debt amount. Any portion that is not added back to rates will reduce rates over all, resulting in savings to purchasers/payers of hospital care. For FY 2010, the savings to purchasers/payers of care was 7.39 percent of the averted bad debt amount. Table 2 illustrates the calculations used for establishing the expected averted bad debt and assessment amount for FY 2010.

Table 2: Medicaid Expansion FY 2010 Expected Averted Bad Debt Calculations

Calculation of Estimated Reduction to Hospital Uncompensated Care	
DHMH Estimated Expansion Expenditures	
Amount per Enrollee per Month	$535.35
Estimated Number of Enrollees	50,500
DHMH Estimated Total Expansion Expenditures	$324.4 million
Less: Payments Made Outside of Maryland (-6%)	-$19.5 million
Payments Made Inside of Maryland	$305.0 million
Percent Paid to Maryland Hospitals (54%)	$164.7 million
Hospital Gross Charges (Medicaid pays 94% of Charges)	$175.2 million
Crowd Out (-28%) and Lower Use Rate (-18%)	-$71.8 million
*Estimated Reduction to Hospital Rates for Uncompensated Care**	$103.4 million
Calculation of Payment Made to DHMH	
Estimated Reduction to Hospital Rates for Uncompensated Care	$103.4 million
Savings Provided to Payer (-7.39%)	$95.8 million
*Amount Paid to Medicaid (94%)***	**$90.0 million**

Notes: *Numbers in table may not sum due to rounding*

* A portion of this amount was allocated to each hospital based on the percentage of current Medicaid payments made to the hospital for this type of population. The allocated amount for each hospital was used to calculate a percent of revenue which was then used to reduce each hospital's approved UCC. The reduced UCC was used in each hospital's calculation of approved markup, and Approved Revenue was reduced accordingly.

** A portion of this amount was uniformly allocated to each hospital based on its estimated Approved Revenue for FY 2010. Each hospital made monthly payments to DHMH throughout the year.

Additionally, the PAC expansion for emergency services required a $8.7 million adjustment to the initial FY 2010 uniform assessment. However, HSCRC staff made no additional reduction to hospital UCC in rates for PAC for FY 2010.

Determining the Total Charges for Medicaid Expansion Population in FY 2010

The reconciliation process is designed to determine the amount that hospitals actually received in payments for the Medicaid expansion population and to calculate the resulting reduction to UCC from the Medicaid expansion. HSCRC staff compare this UCC reduction to the amount that the HSCRC prospectively removed from the UCC component of each hospital's rate, minus any expected savings to purchasers/payers of care, to determine any discrepancies between the estimated and actual amounts.

Ideally, HSCRC staff could rapidly ascertain the actual payments for the Medicaid expansion population using one data source. Unfortunately, no one data source provides all information needed for this calculation. Instead, Department, HSCRC, and hospital staff worked together to supply, compare, and merge data from three major sources. This merging process has proven challenging for all involved. Table 3 provides a description of the data sources.

Table 3: Data Sources for Determining Actual Medicaid Expansion Populations

Data Source	Data Elements Used in Determining Actual Charges	Data Restrictions
Medicaid MCO encounter data	Patient Name, Hospital Name, SSN, Dates of Service	MCO encounter data do not include charges associated with the encounter
HSCRC inpatient and outpatient discharge data	Hospital ID, Patient Account Number, Medical Record Number, Dates of Service, Charges	Data do not distinguish Medicaid expansion population from other Medicaid coverage groups; until FY 2012 did not require Medicaid ID
Hospital data sources	Patient Name, Hospital ID, SSN, Patient Account Number, Medical Record Number, Dates of Service, Charges	Data do not routinely distinguish Medicaid expansion population from other Medicaid coverage groups

Approximately one year after the end of the fiscal year for which averted bad debt had been estimated (e.g., end of FY 2011 for all FY 2010 data), the Commission receives complete reimbursement data from the hospitals and the Department.[2] During the reconciliation process, the Department sends encounter data with patient identifiers to the hospitals; the hospitals send claims with patient identifiers and charges to the HSCRC; and the HSCRC sends results of the matching protocol back to hospitals and the Department. The process iterates until all Medicaid encounter data are populated with the hospital charges associated with the encounter. Table 4 shows the resulting matched and unmatched claims from this process for FY 2010.

Table 4: FY 2010 Medicaid Expansion Claims Reconciliation

Data Source Matching Process	**Claim Count**	**Percentage of Total**
Total claims submitted from hospitals in FY 2010	121,126	
Additional claims submitted in FY 2009 with FY 2010 DOS	2,020	
Total initial claims in reconciliation process	***123,146***	**100%**
Excluded claims:		
Reported with FY 2010 with FY 2011 DOS	508	
Reported in both FY 2009 and FY 2010	10	
PAC (not reconciled in FY 2010)	34	
Unregulated claims	1,964	
Duplicate claims	1,413	
Pregnancy-related services (not expansion population)	7,212	
Total excluded claims	***11,141***	**9.0%**
Total claims with charges identified	**110,428**	**89.7%**
Imputed charges:		
Claims not found by hospitals	**1,439**	**1.2%**
Claims with charges not provided by hospitals	**138**	**0.1%**
Result: Total charges for Medicaid expansion population in FY 2010:	***$125.5 million***	

[2] One year is required to account for the claims "run-out," a period that includes the time providers have to submit claims after providing a service, the time MCOs have to pay the claims, and the time established for MCOs to submit encounter data to the Department.

Applying Crowd Out and Lower Use Rates to Determine the Actual Averted Bad Debt

Once HSCRC staff finalize the encounter data reconciliation process, Commission staff sums total charges for the Medicaid expansion population for each hospital. HSCRC staff then calculates the actual UCC by applying the crowd out and lower use rate estimates to these total charges. Note that for purposes of this options paper, we refer to this amount as the "actual" reduction to UCC resulting from the Medicaid expansion. In practice, however, there is a continued amount of estimation involved in the calculation as the crowd out and lower use rates applied to the total charges are themselves estimates.

Crowd Out and Lower Use Rate Estimates Built into the FY 2010 Projected Averted Bad Debt Calculation

In 2009, when the Department and Commission staff were considering the averted bad debt methodology, there was significant discussion regarding the most appropriate crowd out assumption. While all agreed that the HSCRC should apply crowd out and lower use rate factors, the most appropriate magnitude of the factors was not clear. The Department and the Commission reviewed available literature regarding crowd out and determined that 28 percent was reasonable and appropriate. The group also agreed to an 18 percent lower use rate. HSCRC staff prospectively applied these adjustment factors to calculate projected averted bad debt.

Reconsideration of Crowd Out and Lower Use Rate Estimates Due to the Economic Environment in FY 2010

Following the September Commission meeting, HSCRC staff further engaged in discussions with Department, hospital, and payer representatives to discuss averted bad debt for FY 2010. HSCRC staff aimed to better understand if economic circumstances in FY 2010 necessitate adjustments when retrospectively applying adjustment factors to the calculation of actual averted bad debt.

HSCRC staff recognize the importance of applying the most accurate adjustment factors. When applied to the total hospital charges to Medicaid due to the expansion, the crowd out and lower use rate estimates significantly impact the final calculation of overpayments/underpayments to DHMH. Commission staff conducted sensitivity testing and determined that each percent change in the crowd out estimate produces a $896,000 increase or decrease to the overpayment/ underpayment. Likewise, each percent change in the lower use rate produces a $797,000 increase or decrease to the overpayment/underpayment.

To determine the most appropriate crowd out and lower use rate adjustment factors, HSCRC staff engaged stakeholders in a process which included discussions with the individual parties, independent literature research, review of research provided by the Department, and the facilitation of two in-person meetings among the interested parties.

In much literature, crowd out is the substitution of public insurance coverage for private insurance coverage, such as, the explicit dropping of an employer policy when one is made

eligible for Medicaid. Crowd out cannot be determined simply by looking at an individual's coverage in a prior period. For example, if an individual loses employment and employer sponsored health coverage and then enrolls in Medicaid, this is not considered crowd out. Likewise, if an individual's employer chooses to no longer offer employer sponsored health coverage and then the individual then enrolls in Medicaid, this also is not considered crowd out.

Based on our review of MHA data provided to HSCRC staff by the Department, HSCRC staff recommends lowering the crowd out rate in the FY 2010 actual averted bad debt calculation from 28 percent to 18.22 percent. The MHA data from FY 2009 demonstrated that 10.65 percent of a large sample of the Medicaid expansion population receiving hospital services had commercial insurance in the previous year. While this does not completely address crowd out, in the absence of other data, the HSCRC staff accept this number as a proxy for commercial crowd out among the expansion population.

However, HSCRC staff also recognizes that a portion of the population enrolled in Medicaid the previous year are eligible for Medicaid only due to their falling into what is known as the "spend down eligibility category.[3] Individuals in a spend down eligibility category may or may not qualify for Medicaid outside of the limited spend down period. Therefore, HSCRC staff allocated a portion of the Medicaid spend down population as "crowd out" for purposes of calculating actual averted bad debt. Including the spend down population with the commercial crowd out proxy increases the crowd out rate to 18.22 percent.

HSCRC staff also discussed the lower use rate with the participating parties. However, HSCRC recommends maintaining the lower use rate at 18 percent. The Department staff made a logical argument based on overall expenditure trends that the lower use rate should decrease. However, the supporting data provided by the Department did not provide HSCRC staff a reduction amount to apply to our calculations. We suggest that the Department continue to refine data extracts to better quantify the most appropriate lower use rate for FY 2011.

While reviewing crowd out and lower use rates with stakeholders, payer representatives recognized an error in our including savings to the payers as a component of calculating the actual averted bad debt. Savings to payers should not be considered as a component of the reconciliation process. We have removed this component from our calculations.

Calculation of Overpayments/Underpayments to DHMH for FY 2010

As shown in Table 5, for FY 2010, the encounter data reconciliation process identified $125.5 million in total hospital charges associated with the Medicaid expansion. Appling the crowd out rate (18.22 percent) and lower use rate (18 percent), HSCRC staff calculated the actual reduction to bad debt as $84.2 million. The net aggregate difference in what was paid by hospitals to the Department in the form of a uniform assessment, and the amount paid by the Department to hospitals for this population was $10.9 million.

[3] In Maryland Medicaid, a categorically Medicaid eligible individual with an income that exceeds Medicaid's income enrollment standard may qualify for temporary Medicaid enrollment if he or she has medical bills that equal or are greater than the income in excess of the Medicaid income standard.

Since the assessment was applied as a uniform percentage of revenue, the Commission also calculates the difference in the assessment amount and the actual amount of Medicaid payments for the expansion population. The Commission then adjusts the uncompensated care provision of hospitals to reflect this difference.

Table 5: Medicaid Expansion FY 2010 Reconciliation of Actual Averted Bad Debt

Calculation of Actual Averted Bad Debt	
Actual Reduction to Hospital Rates for Uncompensated Care*	$104.7 million
Total Hospital Charges to Medicaid Due to Expansion	$125.5 million
Reduced for Crowd Out (-18.22%) and Lower Use Rate (-18%)	
Actual Reduction to Uncompensated Care Due to Expansion	*$84.2 million*
Calculation of Overpayment/Underpayment to DHMH	
Actual Reduction to Uncompensated Care Due to Expansion	$84.2 million
Amount Paid by Medicaid to Hospitals (94%)	$79.1 million
Amount Paid to Medicaid by Hospitals	$90.0 million
Difference	***$10.9 million***

Notes: *Numbers in table may not sum due to rounding*

* The actual reduction to hospital rates for UCC ($104.7 million), calculated retrospectively, differs from the estimated reduction to hospital rates for UCC in Table 2 ($103.4 million), calculated prospectively.

Averted Bad Debt Estimates FY 2009 – FY 2012

Table 6 shows the averted bad debt assessment amounts for FY 2009 through FY 2012. The assessment amount has increased from $24.2 million in FY 2009 to $157.7 million in FY 2012. This increase is due primarily to the ramp-up in enrollment during that period. The FY 2011 and 2012 estimates include the PAC costs.

Table 6: Averted Bad Debt Assessment Amounts, FY 2009 - FY 2012
(Dollars in Millions)

	Original Estimate FY 2009	Revised Estimate FY 2009	Estimate FY 2010	Estimate FY 2011	Estimate FY 2012
Estimated Medicaid Total Expenditures	$95.2	$160.1	$324.4	$457.6	$535.0
In State Payment Percent In State Payments	94% $89.5	94% $150.5	94% $305.0	94% $430.2	94% $502.9
Medicaid Payment Percent Charges at Payment Rate	94% $95.2	94% $160.1	94% $324.4	94% $457.6	94% $535.0
Hospital Portion Hospital Charges Reported	61% $58.1	61% $97.7	54% $175.2	47.61% $217.9	43% $230.1
Crowd Out (28%) Charges after Crowd Out	72% $41.8	72% $70.3	72% $126.1	72% $156.9	72% $165.6
Lower Use Rate Estimated Medicaid Averted Bad Debt	82% $34.3	82% $57.7	82% $103.4	82% $128.6	82% $135.8
Estimated PAC Averted Bad Debt	$0	$0	$0	$26.8	$31.9
Hospital Charges including Medicaid Expansion and PAC	$34.3	$57.7	$103.4	$155.4	$167.7
Medicaid Payment Percent Net Medicaid Payments	94% $32.2	94% $54.2	94% $97.2	94% $146.1	94% $157.7
% Returned to Medicaid Hospital Payments to Medicaid	75% $24.2	75% $40.7	92.61% $90.0	100% $146.1	100% $157.7
Total Payments to Medicaid		**$40.7**	**$90.0**	**$146. 1**	**$157. 7**

HSCRC and the Department staff have refined the assumptions used to estimate the expected hospital averted bad debt in FY 2011 and FY 2012. For example, HSCRC staff have considerably reduced the assumption regarding the portion of total Medicaid expansion dollar associated with hospital charges. In FY 2009, the Department estimated and HSCRC staff applied a 61 percent hospital portion. For FY 2012, HSCRC assumes a hospital portion of 43 percent.

It is also notable that prior to the FY 2009 reconciliation, the Department argued that enrollment had grown at a greater rate than initially expected. The Department provided evidence to show that this growth in enrollment would result in a $16.9 million underpayment in FY 2009. The Commission increased the FY 2010 assessment by that amount to address the projected underpayment (see the Revised Estimate FY 2009 column in Table 6).

Options for FY 2010 Reconciliation

Based on the hospital claims reconciliations, HSCRC staff calculated a $10.9 million difference in the FY 2010 actual and assessment amounts associated with averted bad debt. Below are a series of the options for Commission consideration to address the discrepancy.

Option 1* – *Reduce Future Assessment Payments to the Department

Under this option, the Commission would include the expected averted bad debt amount in rates for a given year (FY 2012 for example), but require hospitals to pay a reduced assessment amount to the Department. The reduced assessment amount ($157.7 million - $10.9 million = $146.8 million) could be applied in one year (FY 2012), or phased in over a 2 or 3 year period.

Implication: This option would result in increasing Medicaid deficits in the year(s) that the assessment is reduced. As a result, the Department may choose to increase the deficit assessment amount in future years to reflect the reduction in the averted bad debt assessment. The Department could also resort to other administrative or benefit restrictions, such as the Medicaid day limits that were imposed in prior fiscal years.

Option 2* – *Increase Hospital Rates in FY 2012 to Reflect the Overpayment Amount

The Commission could increase rates above the estimated averted bad debt assessment in a given year but keep the amount of the assessment at the expected amount. This strategy would add $168.6 million ($157.7 million + $10.9 million) to hospital rates, but hospitals would only pay $157.7 million to the Department for the averted bad debt assessment in FY 2012.

Implication: This option would make the hospitals whole for the FY 2010 overpayment, but purchaser/payers of care would then have paid the assessment twice--once in FY 2010, and again in FY 2012.

Option 3* – *Take No Action to Alter the Averted Bad Debt Estimated or Assessment Amounts in Future Years (FY 2012 or beyond)

If no action is taken, hospitals would have overpaid the Department for averted bad debt in FY 2010 in the amount of $10.9 million. This amount would have been reflected in the hospitals' operating budgets and profit margins for that year. The overall hospital operating profit margin in FY 2010 was $329.5 million (2.61 percent). The overpayment represents 0.1 percent of the total profit margin in FY 2010. However, there would be a differential impact on individual hospital margins based on the amount of total payments that the Department made to a hospital for the expansion population in FY 2010.

Implication: Under this option, hospitals would not be permitted to recover any of the FY 2010 overpayment amount which negatively impacted their profit margins in that year.

Option 4* – *Adopt a Combination of Any of Options 1 through 3

If it is the desire of the Commission to disperse the impact of the overpayment among hospitals, payers, and the Department, the Commission could share those costs using a combination of the options described above.

Attachment 1

STATE OF MARYLAND
DHMH
Maryland Department of Health and Mental Hygiene
201 W. Preston Street • Baltimore, Maryland 21201
Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – Joshua M. Sharfstein, M.D., Secretary

August 19, 2011

John M. Colmers
Chairman
The Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Chairman Colmers,

I am following up on my comments at last week's Commission meeting. The Commissioners asked if the 28 percent point crowd out factor was prepared prior to the economic downturn and, if so, whether it was revised to reflect the current economic climate. The answers are that: (1) the factor was prepared before the downturn; and, (2) it has not been revised, meaning changed. But the Department and the Health Services Cost Review Commission (HSCRC), with FY 2009 data supplied by the hospitals, conducted an analysis last year concerning the crowd out factor. Based on that analysis, the data suggest that the crowd out factor is overstated by perhaps 10 percentage points or higher. Additional details are included, below.

As you know, "crowd out" refers to the substitution of public programs for private arrangements. In the health care context, it means those abandoning private insurance to take advantage of public health care initiatives. When investigating this issue, the Maryland Hospital Association (MHA) identified a sample of Medicaid expansion claims from FY 2009. (*See* attached.) MHA's analysis suggests that the original crowd out figure of 28 percent may be understated and actually closer to 55 percent. In generating this figure, however, the hospitals examined their records to identify those who had health insurance in the prior year and, by so doing, included data of those who do not meet the crowd out definition.

Toll Free 1-877-4MD-DHMH – TTY/Maryland Relay Service 1-800-735-2258
Web Site: www.dhmh.state.md.us

Crowd-out takes into consideration only those who elect to drop insurance and enroll in a public benefit program. It does not include those who lose insurance coverage. Many individuals lose coverage for reasons beyond their control, *e.g.*, loss of employment. Similarly, the MHA crowd-out estimates includes those individuals whom the hospitals identify as having had Medicaid coverage in the prior year – this accounts for roughly 44 percent of their 55 percent crowd out estimate. Including all of the Medicaid individuals is an incorrect assumption that artificially inflates the ultimate crowd out number.

Individuals lose Medicaid coverage all the time. The reasons for such loss of coverage vary. For example, some may have incomes that increase beyond the income threshold guidelines. Others may have been granted coverage because of a pregnancy and lost coverage because eligibility for such person extends only up to two months post-partum. These types of churning on and off Medicaid will continue with the Medicaid expansion anticipated by the Affordable Care Act (ACA). National estimates show that within six months after the start of the expansion, more than 35 percent of all adults with family incomes below 200 percent of the federal poverty level will experience a shift in eligibility from Medicaid to an insurance exchange, or the reverse. That estimate increases to 50 percent within one year after the start of the expansion.[1] Whether individuals have Medicaid coverage in the prior year does not equate to crowd-out.

To ensure that the Department's system for identifying expansion enrollees is accurate, the Department sampled 61 claims provided by Maryland hospitals. In our analysis of these claims, the Department determined:

- 31 percent were parents whose income increased beyond the prior income thresholds (39 percent of the federal poverty level).
- 28 percent were pregnant and would have lost coverage two months after giving birth if the state had not raised parent income thresholds.
- Five percent of the sample included dependent children who aged out of the Maryland Children's Health Program (MCHP). Under the family coverage group, Maryland is able to cover dependent children up to age 21, which is two years beyond what is allowed under MCHP.
- Two percent were covered under the Primary Adult Care program - likely the individual had a baby and was now eligible for full Medicaid benefits.
- 34 percent were individuals who had medical expenses in the previous year and were able to spend-down their income in order to qualify. To qualify for coverage in the next year, these individuals would again need medical bills that would permit them to spend-down to a level sufficient to qualify for again for coverage.

[1] "Issues in Health Reform: How Changes In Eligibility May Move Millions Back and Forth Between Medicaid and Insurance Exchanges," Benjamin D. Sommers and Sara Rosenbaum, Health Affairs, February 2011.

The only individuals who may have been covered under Medicaid are those who qualified by spending down their income. There is no guarantee these individuals would have been covered in the following year.[2] Even assuming conservatively that half of the spend-down population now covered under the parent expansion would have been able to qualify under the spend-down requirements, the total crowd out factor using the MHA data would have been around 18 percent – less than the 28 percent factor used by HSCRC and the Department (and far less than the 55 percent estimate of the MHA).

As it appears that the crowd out issue is of interest to the Commission, I am providing this data to further inform your deliberations. Please let me know if you have any questions.

Sincerely,

Tricia Roddy

Tricia Roddy
Director
Planning Administration

cc: Charles J. Milligan, Jr.

[2] The Department compared the average enrollment in FY 08 to the average enrollment in FY 09 for the medical spend-down population. The average enrollment in FY 08 was 2,172 and in FY 09 it was 2,339.

FY 2009 Medicaid Expansion Charges

	FY 09 Expansion	FY 09 Medicaid Secondary Payor		FY 08 Medicaid FFS and MCO "crowd out"		FY 08 Commercial "crowd out"		Combined Medicaid and Commercial "crowd out"
1 Union of Cecil	1,790,925	208,816	11.66%	734,093	40.99%	419,895	23.45%	64.44%
2 Harford Memorial	335,573	58,903	17.55%	248,864	74.16%	27,806	8.29%	82.45%
3 St. Agnes	1,991,624	121,882	6.12%	688,360	34.56%	205,200	10.30%	44.87%
4 Suburban Hospital	170,909	4,075	2.38%	-	0.00%	-	0.00%	0.00%
5 Carroll Hospital Center	1,250,851	108,952	8.71%	457,266	36.56%	179,745	14.37%	50.93%
6 Western Maryland	2,073,266	-	0.00%	361,850	17.45%	233,557	11.27%	28.72%
7 Anne Arundel	880,019	64,803	7.36%	463,766	52.70%	260,772	29.63%	82.33%
8 Johns Hopkins Bayview	3,609,381	282,521	7.83%	1,551,521	42.99%	23,309	0.65%	43.63%
9 Washington County	337,303	69,340	20.56%	131,729	39.05%	69,682	20.66%	59.71%
10 Johns Hopkins Hospital	6,837,698	407,139	5.95%	4,821,968	70.52%	322,992	4.72%	75.24%
11 Howard County	1,034,051	103,734	10.03%	490,054	47.39%	30,494	2.95%	50.34%
12 Garrett County	595,128	10,320	1.73%	372,814	62.64%	89,480	15.04%	77.68%
13 St. Mary's	773,700	10,754	1.39%		0.00%		0.00%	0.00%
14 Franklin Square	3,109,294	287,131	9.23%	2,044,319	65.75%	542,723	17.45%	83.20%
15 Good Samaratin	1,504,122	97,790	6.50%	399,546	26.56%	70,371	4.68%	31.24%
16 Harbor	1,753,741	39,395	2.25%	1,132,596	64.58%	259,669	14.81%	79.39%
17 Union Memorial	2,140,995	59,357	2.77%	581,534	27.16%	151,533	7.08%	34.24%
18 Montgomery General	340,045	5,433	1.60%	76,508	22.50%	50,338	14.80%	37.30%
19 Bon Secours	181,797	9,309	5.12%	29,411	16.18%	78,182	43.01%	59.18%
20 Doctors	194,039	58,312	30.05%	25,805	13.30%	37,725	19.44%	32.74%
21 Mercy	2,203,028	209,007	9.49%	1,194,487	54.22%	281,203	12.76%	66.98%
22 Peninsula	3,092,152	792,139	25.62%	761,716	24.63%	478,414	15.47%	40.11%
23 Frederick Memorial	1,200,543	114,861	9.57%	83,795	6.98%	170,237	14.18%	21.16%
	$37,400,184	$3,123,973	8.35%	$16,652,002	44.52%	$3,983,327	10.65%	55.17%

Attachment 2

STATE OF MARYLAND
DHMH
Maryland Department of Health and Mental Hygiene
201 W. Preston Street • Baltimore, Maryland 21201
Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – Joshua M. Sharfstein, M.D., Secretary

September 14, 2011

John M. Colmers
Chairman
The Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Chairman Colmers,

Last week, the Staff of the Health Services Cost Review Commission (HSCRC) released "Options for Reconciliation of FY 2010 Averted Bad Debt Estimates to Actual."

It is our view that this paper does not provide an adequate basis for decision-making. We ask that the Commission defer action until further analytic work can be completed. The Department is ready and willing to work with the Commission staff to develop a reasonable approach to the matter at hand.

Our significant concerns with the staff paper include the failure to use actual data where such data are available, and the failure to adjust for the effects of the recession. Where the Department has raised important data and analysis for consideration, the staff paper provides no substantive response.

Failure to use actual data where available. The staff paper assumes a crowd out rate of private insurance of 28 percent. However, the Commission is aware of actual data showing that only about 10 percent of the covered population had private insurance in the previous year (and some of those individuals may have gone on to lose that coverage). The paper provides no meaningful response to the Department's perspective that 28% is not the crowd out rate borne out by actual experience.

As a result, the paper significantly understates (by as much as $16 million) the averted uncompensated care.[1]

[1] The Department also responded to the suggestion that the HSCRC should change the definition of crowd out to include those individuals whom the hospitals identify as having had Medicaid coverage in the prior year. Medicaid frequently sees high churn rates (individuals who come on and off of Medicaid), so it is no surprise that many of the individuals who qualify for the expansion may have been covered by Medicaid previously. Including all of the Medicaid individuals is an incorrect assumption that artificially inflates the ultimate crowd out number. Again, there was no substantive response to the Department's analysis of this issue.

Toll Free 1-877-4MD-DHMH – TTY/Maryland Relay Service 1-800-735-2258
Web Site: www.dhmh.state.md.us

The Department also requests the opportunity to share actual data on the use of hospital services with the Commission. The staff paper assumes a constant rate of increased use of hospital services among the insured. But there is now empirical evidence that the expansion population's hospital services use rate is declining. The data show that in the first year of coverage, the expansion population used hospital services at a rate higher than in the subsequent year while covered by Medicaid. This is consistent with the observation that newly insured individuals use more services quickly because of pent-up issues, but that this subsides over time. Without access to this actual data, the paper significantly understates (by as much as $8 million) the averted uncompensated care.

Failure to adjust for the effects of the recession. Members of the Commission and the Department have pointed out that the recession's impact is directly relevant to the issue at hand. As unemployment rose, so did loss of health insurance, reducing crowd out and increasing the value of averted uncompensated care as a result of the expansion. The Staff paper again fails to provide a substantive response on this issue.

The Department is supportive of a fair and timely resolution to this issue. We are ready to work with Commission staff to achieve this result.

Sincerely,

Joshua M. Sharfstein, M.D.
Secretary

cc: Eloise Foster, Secretary
Department of Budget and Management

Charles J. Milligan, Jr., Deputy Secretary
Health Care Financing, DHMH

2

Attachment 3

Maryland
Hospital Association

MHA
6820 Deerpath Road
Elkridge, Maryland 21075-6234
Tel: 410-379-6200
Fax: 410-379-8239

September 9, 2011

John M. Colmers
Chairman, HSCRC
Vice President, Health Care Transformation and Strategic Planning
Johns Hopkins Medicine
3910 Keswick Road, Suite N-2200
Baltimore, MD 21211

Dear Chairman Colmers:

On behalf of our 66 member organizations, I am following up on comments made at the August public meeting on averted uncompensated care (UCC) estimates related to Medicaid expansion and to provide our recommendations on how to handle the Fiscal Year (FY) 2010 overestimate of averted UCC and resulting $25.5 million overpayment to Medicaid.

MHA Supports Medicaid Expansion

In July 2008, the Maryland Hospital Association (MHA) supported the expansion of Medicaid and the mechanism by which the expansion was funded. Expanded Medicaid coverage reduces UCC and builds on a founding concept of the Maryland all-payor system--ensuring access to care. The Medicaid expansion funding mechanism as envisioned in July 2008, provided advantages for all the major stakeholders: commercial payors contributed funding and in exchange saw an equivalent reduction in hospital rates in anticipation of reduced uncompensated care; the public benefitted from a reduction in the uninsured; hospitals benefitted by having a greater share of their patients covered by insurance. However, the finely balanced movement of funds from payors through hospitals to Medicaid and back to hospitals was moved out-of-balance by overestimating the magnitude of averted UCC and resulted in overpayments to the Medicaid program, as shown in Figure 1 below.

Figure 1: FY 2010 Net Averted UCC Funding (in millions)

Estimated Averted UCC

	Rate Increase (Assessment)	Rate Reduction (Prospective)	Payment to Medicaid (Net of mark-up)	Payment for Hospital Services	Net Favorable (Unfavorable)
Payors	$(104.7)	$104.7			$ -
Hospitals	$104.7	$(104.7)	$(90)	$64.5*	$(25.5)
Medicaid			$90	$(64.5*)	$25.5

*$64.5M does not equal the $74.1M actual averted UCC because of the 7.39 percent savings to payors

- more -

Averted UCC Estimate Likely Overstated in FY 2011 and FY 2012

The FY 2010 estimate of averted UCC was $104.7 million, but actual averted UCC is $74.1 million. FY 2011 and FY 2012 estimates of averted UCC are also likely higher than actual averted UCC. From FY 2009 to FY 2010--the years in which newly eligible individuals were rapidly enrolling--actual averted UCC grew 64 percent. Beginning in FY 2011, the pace of new enrollment was expected to have slowed significantly. However, FY 2011 estimated averted UCC is significantly greater than FY 2010 actual averted UCC. As demonstrated in Figures 2 and 3 below, FY 2011 actual averted UCC will need to increase 92 percent beyond FY 2010 actual averted UCC to reach the level of FY 2011 estimated averted UCC. Further, FY 2012 actual averted UCC will have to grow by 103 percent compared to FY 2010 to meet the current FY 2012 estimates. Trends in expected enrollment and per member per month (PMPM) cost do not support dramatic increases in actual averted UCC.

Figure 2: **Actual UCC Increases Necessary to Meet Projections**

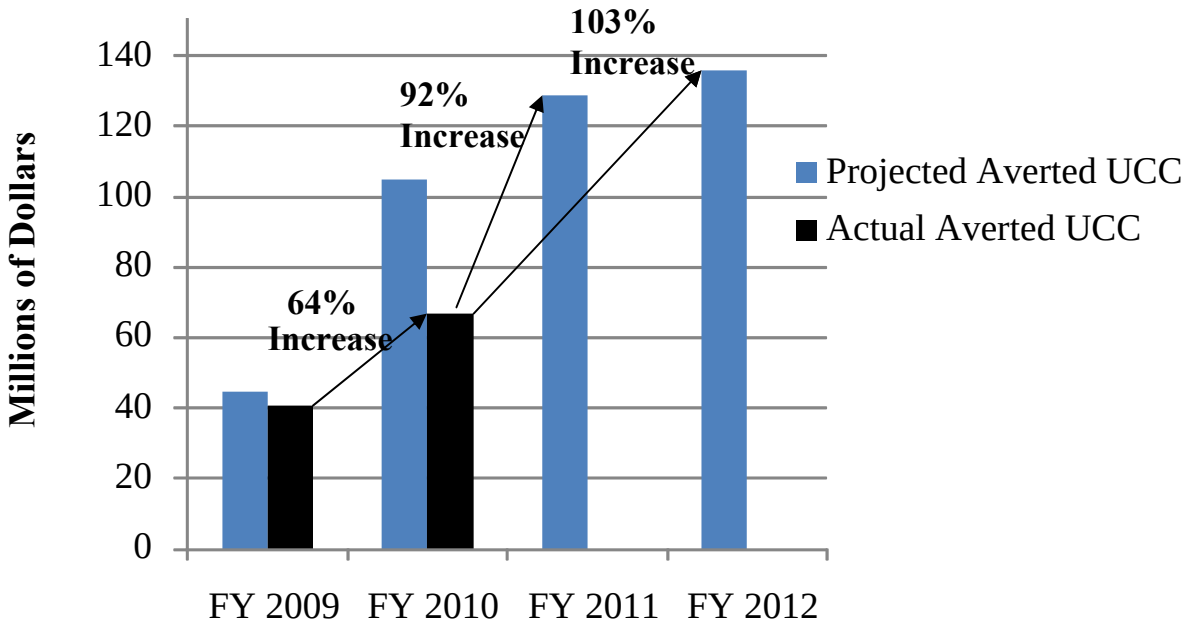


Figure 3: **Medicaid Enrollment and Cost Trends**

	FY 2009	FY 2010	FY 2011	FY 2012
Number of Enrollees	29,273	55,000	69,773	82,000
PMPM Cost Estimate	$511	$539	$546	$570

Recommendation: To reconcile the FY 2010 overpayment to Medicaid, MHA recommends the Health Services Cost Review Commission (HSCRC) reduce hospitals' FY 2012 planned payments to the Maryland Medicaid program by the amount of the overpayment, calculated at $25.5 million. Withholding the $25.5 million FY 2010 overpayment from payments hospitals are scheduled to make to Medicaid in FY 2012 resolves the funding imbalance between hospitals and Medicaid, holds payors harmless, and is consistent with HSCRC policy to reconcile

estimates of averted UCC once actual experience is known.[1,2] In addition, due to higher than anticipated state revenues of $344 million at the end of FY 2011, the state would be in a position to fund the repayment of hospitals' overpayments to the Medicaid program.[3]

Estimating the Amount of Averted Uncompensated Care is a Challenge

Estimating the amount of averted UCC is inexact and relies on assumptions. Medicaid and HSCRC must estimate averted UCC because actual data is not available until at least 15 months after the end of each fiscal year.[4] The estimate of averted UCC is calculated by adjusting expected Medicaid costs for "crowd-out" (28 percent) and the lower use rate of health services by the uninsured (82 percent). **In the process of truing up the original estimates to actual experience it is important to use the same assumptions as those on which the original estimates were made**. The purpose of the reconciliation process is to settle any over or under-estimates of original adjustments. It is not appropriate to retroactively change assumptions during the reconciliation process to meet a fiscal target.

Defining Crowd-Out

In the Maryland Medicaid expansion and averted UCC context, crowd-out is one adjustment used to derive an estimate of averted UCC from the cost Medicaid expects to pay for expansion coverage. The purpose of the crowd-out adjustment is to estimate averted UCC, and should therefore include everyone who had prior coverage--including Medicaid--and would have lost that coverage had the expansion not occurred. HSCRC and Medicaid consider crowd-out to include only those whose private coverage was displaced by the expansion of public coverage. While this more limited definition is an important public policy question to consider when policy makers are deciding whether to expand coverage, excluding individuals who would have retained eligibility for Medicaid under existing requirements substantially understates the amount of UCC averted by Medicaid expansion.

Literature Review on Crowd-Out Estimates Hugely Variable

The Robert Wood Johnson Foundation (RWJF) in its Synthesis Report on Crowd-Out[5] concludes, *there will always be some level of crowd-out with any public program expansion and measuring it with precision will always be difficult. A general midpoint of the studies reviewed indicated an overall substitution effect of 25 to 50 percent with lower rates of substitution for*

[1] Legislative Report: Health General Article Section 19-214 (e) to Governor O'Malley, President Miller, and Speaker Busch on aggregate reduction in hospital uncompensated care realized from the expansion of health care coverage. January, 2010

[2] Legislative Report: Health General Article Section 19-214 (e) to Governor O'Malley, President Miller, and Speaker Busch on aggregate reduction in hospital uncompensated care realized from the expansion of health care coverage. December, 2010

[3] As reported in the *Baltimore Sun*, September 1, 201, Maryland FY 2011 revenues exceeded estimated revenues by nearly $1 billion, although the state plans to use $590 million to balance the current budget.

[4] Managed Care Organizations have 18 months after the date of service to report encounter data to Medicaid. Medicaid uses this encounter data to identify expansion patients that have received hospital services.

[5] *Revisiting Crowd Out*, The Synthesis Project: New Insights from Research Results. The Robert Wood Johnson Foundation. September, 2007.

low-income children (0-15 percent) and higher rates for higher-income children and longer-term enrollees (35 to 50 percent). Appendix 1 represents a literature review from the RWJF report as well as published studies gathered by MHA staff. The literature review shows a crowd-out range between 0 and 68 percent. A number of limitations are cited by the published studies, most notably the difficulty in establishing a counterfactual or comparison group. A study by Long et al (2006) uses multiple control groups and gets different outcomes depending on the control group.[6]

Verifying the Magnitude of Crowd-Out

It is not feasible to unequivocally verify the amount of crowd-out--individuals who had and would have retained coverage had the expansion not occurred. However, data collected by MHA cast doubt on the 28 percent crowd-out assumption used to estimate averted UCC and may indicate a substantial overstatement of averted UCC. MHA believes that a large percentage of patients who had Medicaid coverage in the prior year are being counted in the expansion population even though they would have retained coverage in the absence of the expansion.

MHA collected data from a representative sample of hospitals, including about half of Maryland's acute care hospitals. Each hospital matched FY 2009 expansion patients, as identified by the Medicaid program, with the hospital's prior year patient list. In the aggregate, *more than 50 percent of the expansion patients were provided services and covered by insurance at that hospital in the prior year*. In the prior year, approximately 11 percent were covered by commercial insurance and 44 percent by Medicaid fee-for-service or a Medicaid Managed Care Organization (MCO). (See Appendix 2 for detailed results.) One would not expect patients already covered by Medicaid or an MCO to be included in the expansion category. Patients covered by insurance in the prior year cannot be considered averted UCC in the current year unless we are certain they would have lost that coverage in the current year.

MHA collected a second sample of FY 2009 expansion patients to understand why more than 50 percent of the expansion population included patients covered by Medicaid fee-for-service and Medicaid MCOs in the prior year. MHA provided Medicaid with a sample of 100 expansion patients from a representative group of hospitals and asked for documentation demonstrating that the person would have lost Medicaid coverage had the expansion not occurred. The sample was provided on July 7, 2010. On October 2, 2010, Medicaid provided information on 61 of the 100 patients. Medicaid representatives reported the prior year's eligibility category, but no information on individuals' income levels that would have confirmed that all patients in the sample would have lost coverage had the expansion not occurred. The following table demonstrates the results returned by Medicaid.

[6] Are Adults Benefiting from State Coverage Expansions?, *Health Affairs* vol 25., no 2, 2006, Long S., Zuckerman S., Graves JA

Eligibility Category	Number	Cumulative Percent
*Families	19	19%
Pregnant/Family Planning	17	36%
Aged out of MCHP	3	39%
In PAC Program	1	40%
In Spenddown Program	21	61%
Undetermined	39	100%

*The individual's income in 2009 would have had to be between 40-116 percent of Federal Poverty Level to have lost coverage without the expansion.

The Maryland Children's Health Program (MCHP)
Primary Adult Care (PAC) Program

Recommendation: HSCRC and Medicaid should continue to assume crowd-out at 28 percent, and not retroactively change the assumption to meet a fiscal target. The amount of crowd-out is an assumption that cannot be precisely verified. Twenty-eight percent is within the mid-range of studies that show wide variation in crowd-out depending on the population studied and other external factors.

MHA Recommendations

1. **To reconcile the FY 2010 overpayment to Medicaid, MHA recommends the HSCRC reduce hospitals' FY 2012 planned payments to the Maryland Medicaid program by the amount of the overpayment, currently calculated at $25.5 million**. Withholding the $25.5 million FY 2010 overpayment from payments hospitals are scheduled to make to Medicaid in FY 2012 resolves the funding imbalance between hospitals and Medicaid, holds payors harmless, and is consistent with the HSCRC policy. Higher than anticipated state revenues of $344 million put the state in a position to refund hospitals' overpayments to the Medicaid program.

2. **HSCRC and Medicaid should continue to assume crowd-out at 28 percent, and not retroactively change the assumption to meet a fiscal target**. The amount of crowd-out is an assumption that cannot be precisely verified. Twenty-eight percent is within the mid-range of studies that show wide variation in crowd-out depending on the population studied and other external factors. In the process of truing up the original estimates to actual experience it is important to use the same assumptions as those on which the original estimates were made.

MHA appreciates the opportunity to participate in the discussion of this issue. If you have any questions, concerns or would like additional information, please contact me at 410-540-5087.

Sincerely,

Traci Lynn La Valle

Traci La Valle
Vice President, Financial Policy

cc: Stephen Ports, Acting Executive Director, HSCRC

Attachments
Murray's 2009 and 2010 Legislative Reports
Appendix 1 Crowd-out literature summary
Appendix 2 MHA data on prior coverage of expansion patients

Study	Findings	Population studied/Data source	Comments
"Crowd-out Ten Years Later: Have Recent Public Insurance Expansions Crowded Out Private Health Insurance?" by Jonathan Gruber and Kosali Simon (2007)	Estimates **crowd-out between 61 and 68 percent** when an entire family is eligible for public programs; about twice that estimated for individuals.	Adults and children	This study focuses on the impact of families enrolling in coverage. The authors estimate that the **crowd out rate for families is about twice that of individuals.**
"Substitution of SCHIP for Private Coverage: Results from a 2002 Evaluation in Ten States" by Anna Sommers, Stephen Zuckerman, Lisa Dubay, and Genevieve Kenney (2007)	**Crowd out** rate for **newly enrolled children in CHIP** in 2002 was between **7- 14%** depending on whether affordability is included as a reason to voluntarily substitute public coverage for private.	Ten states were selected to include a large proportion of all low-income uninsured children, geographic diversity, and a variety of SCHIP structures. Data was taken from a survey of 16,700 CHIP enrollees in 2002 and state administrative data reporting enrollment history.	The authors found that 28% of new enrollees had private coverage at some point in the six months prior to enrollment. However, half of those lost private coverage involuntarily. Voluntary substitution accounted for only 14% of newly enrolled children in the ten states. Of those that voluntarily substituted, half of parents reported that prior coverage was unaffordable.
"Insuring Low-Income Adults: Does Private Coverage Crowd Out Private?" by Richard Kronick and Todd Gilmer	The study found that **crowd out rate was between 0 and 45 percent**, depending on income level of enrollee.	Current Population Survey (CPS) data from 1998 to 1999 for adults in MN, WA, OR, and TN. Also state administrative data reporting total enrollment among adults each year.	The authors found that among enrollees below 100% of FPL, there was no evidence of crowd out due to expansion. Among enrollees between 100 and 200% of FPL, crowd out accounted for as much as 45%.

Study	Findings	Population studied/Data source	Comments
"Are Adults Benefiting from State Coverage Expansions" by Sharon Long, Stephen Zuckerman, and John Graves (2006)	Lack of uniformity across states makes it **difficult to generalize crowd out estimates** from one state to another. Authors conclude that crowd-out may be small or non-existent in some states.	Used data from the National Survey of American Families (NASF) between 1997 and 2002 for adults in CA, MA, NJ, and WI.	The authors found significant variation in estimates of crowd out both within and across the states that expanded coverage to parents and childless adults. Parents in Wisconsin and parents and childless adults in Massachusetts experienced the largest increase in public coverage, with little offsetting reduction to private coverage. In contrast, expansion to parents in California and New Jersey led to increased enrollment but at the expense of private coverage.
"SCHIP's Impact on Dependent Coverage in the Small Group Market" by Eric Seiber and Curtis Florence (2010)	The study found **crowd out of 8.7 percent** for children with parents employed by a small busines with less than 25 employees and **41.6 percent** for children with parents employed at businesses up to 500 employees.	1996-2007 Annual Demographic Survey of the Current Population Survey (CPS) for children in households with at least one worker.	The authors found that crowd out rate increased with business size.
"Family Coverage Expansions: Impact on Insurance Coverage and Health Care Utilization of Parents" by Susan Busch and Noelia Duchovny (2005)	The study found **crowd out rate for eligible parents was 23.6%.**	Used data from the Current Population Survey (CPS) from 1996 to 2002 for non-disabled parents.	
"The Effects of State Policy Design Features on Take-up and Crowd-out Rates for the State Children's Health Insurance Program" by Bansak and Raphael (2006)	The study estimated **crowd out of 25 to 33 percent for SCHIP-eligible children.**	Used data from 1998 and 2002 CPS nationally for low-income children	**Crowd out for low-income children tends to be lowest of all categories.**

Study	Findings	Population studied/Data source	Comments
"Congressionally-Mandated Evaluation of the State Children's Health Insurance Program: Final Report to Congress" by Woolridge et al (2005)	The study estimated **crowd out of 7 to 14% for newly enrolled children.**	Used case studies and surveys of SCHIP enrollees and disenrollees in 10 states-CA, CO, FL, IL, LA, MO, NC, NJ, NY, and TX	This study finds a **low crowd out rate for children**. Specific rate varies based on affordability and how long a child has been enrolled in SCHIP.
"The Impact of SCHIP on Insurance Coverage of Children" by Hudson JL, Selden TM, Banthin JS (2005)	Estimates of **crowd out for children under 18 was between 42 and 49 percent**	Used Medical Expenditure Survey	The authors suggested that the findings were not conclusive, as some model specifications resulted in no significant crowd-out effects while others showed a significant impact on private coverage
"Does Public Insurance Crowd Out Private Insurance?" by Gruber and Cutler (1996)	Study found **crowd out rate to be between 15 and 50 percent depending on the definition** used for crowd out.	Used CPS data from 1988 to 1993; multi-state.	Results depended on the definitition used for crowd out: 1) the decrease in private coverage as a share of newly eligible Medicaid enrollees (50 percent); 2) the decrease in private coverage as a share of all Medicaid enrollment increases (22 percent); and 3) the percentage decline of private coverage over a period of time attributed to Medicaid enrollment (15 percent).

FY 2009 Medicaid Expansion Charges

		FY 09 Expansion	FY 09 Medicaid Secondary Payor		FY 08 Medicaid FFS and MCO "crowd out"		FY 08 Commercial "crowd out"		Combined Medicaid and Commercial "crowd out"
1	Union of Cecil	1,790,925	208,816	11.66%	734,093	40.99%	419,895	23.45%	64.44%
2	Harford Memorial	335,573	58,903	17.55%	248,864	74.16%	27,806	8.29%	82.45%
3	St. Agnes	1,991,624	121,882	6.12%	688,360	34.56%	205,200	10.30%	44.87%
4	Suburban Hospital	170,909	4,075	2.38%	-	0.00%	-	0.00%	0.00%
5	Carroll Hospital Center	1,250,851	108,952	8.71%	457,266	36.56%	179,745	14.37%	50.93%
6	Western Maryland	2,073,266	-	0.00%	361,850	17.45%	233,557	11.27%	28.72%
7	Anne Arundel	880,019	64,803	7.36%	463,766	52.70%	260,772	29.63%	82.33%
8	Johns Hopkins Bayview	3,609,381	282,521	7.83%	1,551,521	42.99%	23,309	0.65%	43.63%
9	Washington County	337,303	69,340	20.56%	131,729	39.05%	69,682	20.66%	59.71%
10	Johns Hopkins Hospital	6,837,698	407,139	5.95%	4,821,968	70.52%	322,992	4.72%	75.24%
11	Howard County	1,034,051	103,734	10.03%	490,054	47.39%	30,494	2.95%	50.34%
12	Garrett County	595,128	10,320	1.73%	372,814	62.64%	89,480	15.04%	77.68%
13	St. Mary's	773,700	10,754	1.39%		0.00%		0.00%	0.00%
14	Franklin Square	3,109,294	287,131	9.23%	2,044,319	65.75%	542,723	17.45%	83.20%
15	Good Samaratin	1,504,122	97,790	6.50%	399,546	26.56%	70,371	4.68%	31.24%
16	Harbor	1,753,741	39,395	2.25%	1,132,596	64.58%	259,669	14.81%	79.39%
17	Union Memorial	2,140,995	59,357	2.77%	581,534	27.16%	151,533	7.08%	34.24%
18	Montgomery General	340,045	5,433	1.60%	76,508	22.50%	50,338	14.80%	37.30%
19	Bon Secours	181,797	9,309	5.12%	29,411	16.18%	78,182	43.01%	59.18%
20	Doctors	194,039	58,312	30.05%	25,805	13.30%	37,725	19.44%	32.74%
21	Peninsula	3,092,152	792,139	25.62%	761,716	24.63%	478,414	15.47%	40.11%
22	Frederick Memorial	1,200,543	114,861	9.57%	83,795	6.98%	170,237	14.18%	21.16%
		$35,197,156	$2,914,966	8.28%	$15,457,515	43.92%	$3,702,124	10.52%	54.44%

HEALTH SERVICES COST REVIEW COMMISSION
4160 PATTERSON AVENUE, BALTIMORE, MARYLAND 21215
Phone: 410-764-2605 · Fax: 410-358-6217
Toll Free: 1-888-287-3229
www.hscrc.state.md.us

December 29, 2010

The Honorable Martin O'Malley
State House, 100 State Circle
Annapolis, MD 21401

The Honorable Thomas V. Mike Miller, Jr.
H-107, State House
Annapolis, MD 21401-1991

The Honorable Michael E. Busch
H-101, State House
Annapolis, MD 21401-1991

RE: Legislative Report:
Health General Article
Section 19-214(e)

Dear Governor O'Malley, President Miller, and Speaker Busch;

I am writing in response to the provisions set forth in Section 19-214(e) of the Health General Article (as enacted in Chapter 245 of the 2008 Laws of Maryland, House Bill 1587), which requires the Health Services Cost Review Commission ("HSCRC," or "Commission") to report to the Governor and, in accordance with Section 2-1246 of the State Government Article, the General Assembly, the following information:

- The aggregate reduction in hospital uncompensated care realized from the expansion of health care coverage under Chapter 7, Acts of the General Assembly, 2007 Special Session; and

- The number of individuals who enrolled in Medicaid as a result of the change in

eligibility standards under Section 15-103(A)(2)(ix) and (x) of the Health General Article, and the expenses associated with the utilization of hospital inpatient care by these individuals.

Introduction

Over the past several years, the General Assembly has considered various ways to reduce the number of uninsured individuals in the State, which has been estimated roughly to be 800,000. For example, legislation has been introduced to create a health care exchange, increase the eligibility age of dependents for health care coverage purposes, require citizens to obtain coverage or pay a tax penalty, require businesses to provide coverage to employees or pay a subsidy, provide a subsidy for small businesses that have not provided health care coverage to their employees, and expand eligibility for the Medicaid Program.

Senate Bill 6 (Chapter 7) was enacted during the 2007 Special Session, and SB974/HB 1587 (Chapter 244/245) was enacted in 2008 to address several of these issues.

Background

Chapter 7 of the 2007 Special Session enacted the "Working Families and Small Business Health Coverage Act," which expands access to health care in the following ways:

- Expands Medicaid eligibility to parents and caretaker relatives with household income up to 116 percent (currently 46%) of federal poverty guidelines (FPG), to be implemented in fiscal 2009 (116% for family of 4 = $24,000);

- Contingent on available funding, incrementally expands the Primary Adult Care program benefits over three years to childless adults with household income up to 116 percent FPG (currently 46%), to be phased in from fiscal 2010 through 2013; and

- Establishes a Small Employer Health Insurance Premium Subsidy Program, to be administered by the Maryland Health Care Commission (MHCC) and funded with $15 million in fiscal 2009.

Special funds, including savings from averted uncompensated care and matching federal funds, will cover a portion of the costs of the expansion. Chapters 244/245 from 2008 requires the Commission to implement a uniform assessment on hospital rates to reflect the aggregate reduction in hospital uncompensated care from the expansion of health care coverage under Chapter 7. The assessment is to be broad-based, prospective, and uniform and will reflect averted uncompensated care realized from the expansion of the Medicaid Program under Chapter 7. The legislation authorizes the Commission to implement the assessment, provided that it does not exceed the actual averted uncompensated care.

The federal Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991

require that in order for provider taxes to access federal matching funds, they may not exceed 25% of a state's share of Medicaid expenditures; they must be broad-based and uniform; and they may not hold providers harmless. A uniform tax is one that is imposed at the same rate on all providers.

In addition to altering the funding of 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. Under this provision, regulations were adopted by the HSCRC to increase the assessment from the previous requirement of 0.81% to 1.0% of net patient revenue. The combined assessment (averted uncompensated care and MHIP) may not exceed 3% of total net patient revenue at Maryland hospitals.

FY 2009 Uniform Assessment Associated with Averted Bad Debt from Medicaid Expansion

Eligible individuals do not become enrolled in the Medicaid program until many months after care has been provided. Once enrolled, coverage is provided retroactively to the date of the service. In addition, it takes at least 3-6 months after care is provided for all relevant data to be accessed by Medicaid and the HSCRC on the associated costs. Therefore, the amount of averted bad debt is not fully known until many months after the conclusion of the applicable fiscal year. As a result, Medicaid and the HSCRC estimate the aggregate reduction in hospital uncompensated care based on Medicaid's expected enrollment and per member/per month costs. During FY 2008, the Medicaid Program and HSCRC calculated the estimated total Medicaid expenditures for FY 2009 by multiplying the total number of expected member months by the expected monthly Medicaid costs ($462.58). The result, $95.2 million, was adjusted to account for the following:

- The percentage of expenditures that will be spent in-state, 94%, calculated using a three year average of Medicaid claims data;
- Medicaid pays 94% of charges;
- The percentage of expenditures that would go to hospitals (61%) calculated based on the Medicaid HealthChoice reimbursement process that breaks out payment rates into hospital, drug, and other components;
- The estimated share of the spending that was directed to individuals who had coverage previously (known as "crowd out") was 28% based on available literature and confirmed by surveys issued through Medicaid; and
- The lower use rate of the uninsured, approximately 82%, based on the available literature.

Using these adjustments, the original estimated hospital averted bad debt from Medicaid expansion in FY 2009 was calculated to be $34.3 million (See Row 11, Column A of Appendix I for calculations).

The legislation states that a portion of averted bad debt shall be utilized to reduce costs to

purchasers of hospital care, through a reduction in hospital rates. For FY 2009, the Commission determined that 75% of the averted bad debt is to be passed on as reductions in hospital payments related to uncompensated care. Therefore, $24.2 million of the expected averted bad debt was remitted from hospitals to support the Medicaid expansion program (See Row 17, Column A of Appendix I for calculations). Once remitted and utilized for health care purposes by Medicaid, the State is able to access the federal match on this amount – more than doubling this amount (the federal match in FYs 2009 and 2010 is 61.59%).

As reported by the Department of Health and Mental Hygiene ("DHMH"), the average enrollment in Medicaid as a result of Medicaid expansion in FY 2009 was actually 29,273 – an amount higher than expected when the uniform assessment was originally calculated for FY 2009. Moreover, Medicaid found that the per member/per month cost was also higher than originally expected, since a higher proportion of the new enrollees was older than age 44. Typically, an older population requires more health care services, which means higher costs to the program. As a result, the original FY 2009 per member/per month cost estimate was increased from $462.58 to $510.61 – a 10.3% increase.

Factoring in these increases and making adjustments based on experience (such as the hospital portion from 61% to 54%) to date, it has been estimated preliminarily that the amount of averted bad debt in FY 2009 was $16.5 million greater than originally expected (See Row 18, Column B of Appendix I for calculations). This amount has been included in the uniform assessment calculation for FY 2010.

FY 2010 Uniform Assessment Associated with Averted Bad Debt from Medicaid Expansion

The FY 2010 assessment was based on an anticipated average enrollment of 55,000 and a per member/per month cost of $539. The total expected Medicaid expenditures for this population is $324.4 million. After making the same adjustments made for FY 2009, the total expected hospital averted bad debt in FY 2010 is $103.4 million, and the uniform assessment for FY 2010 is $90 million – providing a savings to purchasers of hospital care of about 7.4% or $13 million (See Column C of Appendix I for calculations).

The aforementioned $16.5 million from the underestimation in FY 2009 has been added to this amount so that the total assessment amount for the parents/caretakers expansion in FY 2010 is $106.5 million (See line 19 in Column C in Appendix I).

Expansion to Emergency Care under the Primary Adult Care Program

As described above, Chapter 7 of the 2007 legislation expands services to childless adults with incomes up to 116 percent of the federal poverty level. Currently, the childless adult population receives primary care, pharmacy, and certain office and clinic-based mental health services (the Primary Adult Care Program, or PAC). The Working Families and Small Business Health Coverage Act phases in specialty physician, emergency, and hospital services over a three-year period, if available funding exists. In accordance with Board of Public Works action in July of 2009, emergency services have been added to the PAC program beginning January 1, 2010. This expansion will also require an adjustment to the FY 2010 uniform assessment. This program

required an additional $8.7 million in resources between January 1, 2010 and June 30, 2010. Therefore, this amount has been added to the uniform assessment for a total FY 2010 uniform assessment of $115.2 million.

FY 2011 Uniform Assessment Associated with Averted Bad Debt from Medicaid Expansion

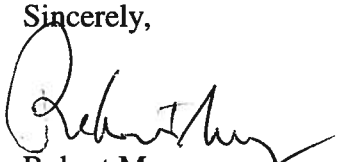
The FY 2011 assessment was based on an anticipated average enrollment of 69,773 and a per member/per month cost of $546. The total expected Medicaid expenditures for this population is $457.6 million. After making the same adjustments made in FY 2009 and 2010, the total expected hospital averted bad debt in FY 2011 is $155.4 million, which includes $128.6 million for the Medicaid Expansion, plus $26.8 million for the PAC program. The uniform assessment for FY 2011 is $146.1 million (adjusted for the conversion of hospital charges to Medicaid payments). There will be no savings to purchasers of hospital care in FY 20011(See Column D of Appendix I for calculations).

Conclusion

Thank you for this opportunity to share data on the impact that the provisions of Chapter 7 from 2007 and Chapter 244/245 from 2008 have had to date on hospital uncompensated care. In a short period of time, these provisions have begun to demonstrate the desired effect of increasing access to health care and reducing hospital uncompensated care. HSCRC policy dictates that since the uniform assessment represents an estimate of bad debt experience, once actual experience is known, the Commission will make "settle-up" adjustments in rates to correct for any error in forecasting.

Future reports will allow for a more comprehensive analysis by utilizing a full year of actual data. The HSCRC will continue to coordinate with DHMH to establish a more efficient and effective means of estimating averted bad debt resulting from the Medicaid expansion legislation, as well as determining the actual amount to be reconciled in hospital rates.

Sincerely,



Robert Murray
Executive Director

cc: Department of Legislative Services Library and Information Services (5 copies)
Senator Thomas Mac Middleton
Delegate Peter Hammen
Secretary John Colmers
Mr. Joseph Bryce (Governor's Legislative Office)
Ms. Marie Grant (DLS)
Ms. Linda Stahr (DLS)
Ms. Wynee Hawk (DHMH)

Appendix I

Estimate vs Actual Averted Bad Debt

Estimated for FY 2009, FY 2010, and FY 2011

		A Original Estimate FY 2009	B Revised Estimate FY 2009	C Revised Estimate FY 2010	D Revised Estimate FY 2011
1	Medicaid Total Expenditures	$95,170,624	$160,119,126	$324,422,100	$457,646,689
2	In State Payment Percent	94.00%	94.00%	94.00%	94.00%
3	In State Payments	$89,460,386	$150,511,978	$304,956,774	$430,187,888
4	Medicaid Payment Percent	94.00%	94.00%	94.00%	94.00%
5	Charges @ Hosp Payment Rate	$95,170,624	$160,119,126	$324,422,100	$457,646,689
6	Hospital Portion	61.00%	61.00%	54.00%	47.61%
7	Hospital Charges Reported	$58,054,080	$97,672,667	$175,187,934	$217,879,100
8	Crowd Out (28%)	72.00%	72.00%	72.00%	72.00%
9	Hospital Charges after Crowd	$41,798,938	$70,324,320	$126,135,312	$156,872,952
10	Lower Use Rate	82.00%	82.00%	82.00%	82.00%
11	**Averted Bad Debt**	**$34,275,129**	**$57,665,943**	**$103,430,956**	**$128,635,821**
12	Medicaid Expenditures for PAC	$0.00	$0.00	$0.00	$26,787,574
13	Hospital Charges after PAC				$155,423,395
14	Medicaid Payment Percent	94.00%	94.00%	94.00%	94.00%
15	Net Medicaid Payments	$32,218,621	$54,205,986	$97,225,099	$146,097,991
16	Percent Returned to Medicaid	75.00%	75.00%	92.61%	100.00%
17	Hospital Payments to Medicaid	$24,163,966	$40,654,489	$90,039,771	$146,097,991
18	**Difference**		**$16,490,523**		
19	Settle up Payment			**$16,490,523**	
20	Total Payments to Medicaid			$106,530,295	

Estimated Enrollees	29,273	55,000	69,773
Cost per Enrollee per member month	$511	$539	$546

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Donald A. Young, M.D.
Chairman

Kevin J. Sexton
Vice Chairman

Joseph R. Antos, Ph.D.

Trudy R. Hall, M.D.

Steven B. Larsen, J.D.

C. James Lowthers

Herbert S. Wong, Ph.D.

HEALTH SERVICES COST REVIEW COMMISSION
4160 PATTERSON AVENUE · BALTIMORE, MARYLAND 21215
Phone: 410-764-2605 Fax: 410-358-6217
Toll Free: 1-888-287-3229
www.hscrc.state.md.us

Robert Murray
Executive Director

Stephen Ports
Principal Deputy Director
Policy & Operations

Gerard J. Schmith
Deputy Director
Hospital Rate Setting

Charlotte Thompson
Deputy Director
Research and Methodology

January 1, 2010

The Honorable Martin O'Malley
State House, 100 State Circle
Annapolis, MD 21401

The Honorable Thomas V. Mike Miller, Jr.
H-107, State House
Annapolis, MD 21401-1991

The Honorable Michael E. Busch
H-101, State House
Annapolis, MD 21401-1991

RE: Legislative Report:
Health General Article
Section 19-214(e)

Dear Governor O'Malley, President Miller, and Speaker Busch;

I am writing in response to the provisions set forth in Section 19-214(e) of the Health General Article (as enacted in Chapter 245 of the 2008 Laws of Maryland, House Bill 1587), which requires the Health Services Cost Review Commission ("HSCRC," or "Commission") to report to the Governor and, in accordance with Section 2-1246 of the State Government Article, the General Assembly, the following information:

- The aggregate reduction in hospital uncompensated care realized from the expansion of health care coverage under Chapter 7 of the Acts of the General Assembly of the 2007 Special Session; and

- The number of individuals who enrolled in Medicaid as a result of the change in eligibility standards under Section 15-103(A)(2)(ix) and (x) of the Health General Article and the expenses associated with the utilization of hospital inpatient care by these individuals.

Introduction

Over the past several years, the General Assembly has considered various ways to reduce the number of uninsured individuals in the State, which has been estimated roughly to be 800,000. For example, legislation has been introduced to create a health care exchange, increase the eligible age of dependents for health care coverage purposes, require citizens to obtain coverage or pay a tax penalty, require businesses to provide coverage to employees or pay a subsidy, provide a subsidy for small businesses that have not provided health care coverage to their employees, and expand eligibility for the Medicaid Program.

Senate Bill 6 (Chapter 7) was enacted during the 2007 Special Session, and SB974/HB 1587 (Chapter 244/245) was enacted in 2008 to address several of these issues.

Background

Chapter 7 of the 2007 Special Session enacted the "Working Families and Small Business Health Coverage Act," which expands access to health care in the following ways:

- Expands Medicaid eligibility to parents and caretaker relatives with household income up to 116 percent (currently 46%) of federal poverty guidelines (FPG), which will be implemented in fiscal 2009 (116% for family of 4 = $24,000);

- Contingent on available funding, incrementally expands the Primary Adult Care program benefits over three years to childless adults with household income up to 116 percent FPG (currently 46%), which will phase in from fiscal 2010 through 2013; and

- Establishes a Small Employer Health Insurance Premium Subsidy Program, which will be administered by the Maryland Health Care Commission (MHCC) and funded with $15 million in fiscal 2009.

Special funds, including savings from averted uncompensated care and matching federal funds, will cover a portion of the costs of the expansion. Chapters 244/245 from 2008 requires the Commission to implement a uniform assessment on hospital rates to reflect the aggregate reduction in hospital uncompensated care from the expansion of health care coverage under Chapter 7. The assessment is to be broad-based, prospective, and uniform and will reflect averted uncompensated care realized from the expansion of the Medicaid Program under Chapter

7. The legislation authorizes the Commission to implement the assessment provided that it does not exceed the actual averted uncompensated care.

The federal Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 require that in order for provider taxes to access federal matching funds, they may not exceed 25% of a state's share of Medicaid expenditures; they must be broad-based and uniform; and they may not hold providers harmless. A uniform tax is one that is imposed at the same rate on all providers.

In addition to altering the funding of 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. Under this provision, regulations were adopted to increase the assessment from the previous requirement of 0.81% to 1.0% of net patient revenue. The combined assessment (averted uncompensated care and MHIP) may not exceed 3% of total net patient revenue at Maryland hospitals.

FY 2009 Uniform Assessment and Estimate of Averted Bad Debt

Frequently, eligible individuals do not become enrolled in the Medicaid program until many months after care had been provided. Once enrolled, coverage is provided retroactively to the date of the service. In addition, it takes at least 3-6 months after care is provided for all relevant data to be accessed by Medicaid and the HSCRC on the associated costs. Therefore, the amount of averted bad debt is not fully known until many months after the conclusion of the applicable fiscal year. As a result, Medicaid and the HSCRC estimate the aggregate reduction in hospital uncompensated care based on Medicaid's expected enrollment and per member/per month costs. During FY 2008, the Medicaid Program and HSCRC calculated the estimated total Medicaid expenditures for FY 2009 by multiplying the total number of expected member months by the expected monthly Medicaid costs ($462.58). The result, $95.2 million, was adjusted to account for the following:

- The percentage of expenditures that will be spent in-state, 94%, calculated using a three year average of Medicaid claims data;
- Medicaid pays 94% of charges;
- The percentage of expenditures that would go to hospitals (61%) calculated based on the Medicaid HealthChoice reimbursement process that breaks out payment rates into hospital, drug, and other components;
- The estimated share of the spending that went to individuals who had coverage previously (known as "crowd out") was 28% based on available literature and confirmed by surveys issued through Medicaid; and

- The lower use rate of the uninsured, approximately 82%, based on the available literature.

Using these adjustments, the original estimated hospital averted bad debt from Medicaid expansion in FY 2009 was calculated to be $34.3 million (See Row 11, Column A of Appendix I for calculations).

The legislation states that a portion of averted bad debt shall be utilized to reduce costs to purchasers of hospital care, through a reduction in hospital rates. For FY 2009, the Commission determined that 75% of the averted bad debt is to be passed on as reductions in hospital payments related to uncompensated care. Therefore, $24.2 million of the expected averted bad debt was remitted from hospitals to support the Medicaid expansion program (See Row 15, Column A of Appendix I for calculations). Once remitted and utilized for health care purposes by Medicaid, the State is able to access the federal match on this amount – more than doubling this amount (the federal match in FYs 2009 and 2010 is 61.59%).

As reported by the Department of Health and Mental Hygiene ("DHMH"), the average enrollment in Medicaid as a result of Medicaid expansion in FY 2009 was actually 29,273 – an amount higher than expected when the uniform assessment was originally calculated for FY 2009. Moreover, Medicaid found that the per member/per month cost was also higher than originally expected, since a higher proportion of the new enrollees was older than age 44. Typically, an older population requires more health care services, which means higher costs to the program. As a result, the original FY 2009 per member/per month cost estimate was increased from $462.58 to $510.61 – a 10.3% increase.

Factoring in these increases and making adjustments based on experience (such as the hospital portion from 61% to 54%) to date, it has been estimated preliminarily that the amount of averted bad debt in FY 2009 was $16.5 million greater than originally expected (See Row 16, Column B of Appendix I for calculations). This amount has been included in the uniform assessment calculation for FY 2010.

FY 2010 Uniform Assessment and Estimated Averted Bad Debt

The FY 2010 assessment was based on an anticipated average enrollment of 55,000 and a per member/per month cost of $539. The total expected Medicaid expenditures for this population is $324.4 million. After making the same adjustments made for FY 2009, the total expected hospital averted bad debt in FY 2010 is $103.4 million, and the uniform assessment for FY 2010 is $90 million – providing a savings to purchasers of hospital care of about 7.4% or $13 million (See Column C of Appendix I for calculations).

The aforementioned $16.5 million from the underestimation in FY 2009 has been added to this amount so that the total assessment amount for the parents/caretakers expansion in FY 2010 is $106.5 million (See line 18 in Column C in Appendix I).

Expansion to Emergency Care under the Primary Adult Care Program

As described above, Chapter 7 of the 2007 legislation expands services to childless adults with incomes up to 116 percent of the federal poverty level. Currently, the childless adult population receives primary care, pharmacy, and certain office and clinic-based mental health services (the Primary Adult Care Program or PAC). The Act phases-in specialty physician, emergency services, and hospital services over a three-year period, if available funding exists. Pursuant to Board of Public Works action in July of 2009, emergency services will be added to the PAC program beginning January 1, 2010. This expansion will also require an adjustment to the FY 2010 uniform assessment. This program is expected to require an additional $8.7 million in resources between January 1, 2010 and June 30, 2010. Therefore, this amount has been added to the uniform assessment for a total FY 2010 uniform assessment of $115.2 million.

Administrative Difficulties

Estimating averted bad debt has been more tedious than expected due to data lags, the inability of Medicaid to identify distinctly the individuals enrolled under the expansion legislation, the inadequacy of the enrollment and data systems at DHMH, the fact that uncompensated care is increasing overall due to other economic factors, and the time burden on staff at Medicaid and HSCRC.

Hospitals have claimed that they are not seeing the same level of averted bad debt that is being estimated. Medicaid, on the other hand, has been finding enrollment higher and more costly than initially estimated. Adding to the dichotomy is inability to provide- patient level information to hospitals in a timely manner to confirm such levels. As we note that uncompensated care continues to increase due to various economic factors, it will be difficult to determine averted bad debt accurately until all relevant data on Medicaid expansion enrollment and costs become available.

Over the past 18 months, HSCRC staff has invested approximately 800 hours in attempting to arrive at the most accurate estimates possible. Since this has not been an efficient use of staff time, the HSCRC, Medicaid, and the hospital industry representatives have been working to find a more efficient and accurate means of identifying the Medicaid expansion population within the HSCRC data.

Conclusion

Thank you for this opportunity to share preliminary data and an estimate of the impact that the provisions of Chapter 7 from 2007 and Chapter 244/245 from 2008 have had to date on hospital

uncompensated care. In a short period of time, these provisions have begun to demonstrate the desired effect of increasing access to health care and reducing hospital uncompensated care. HSCRC policy dictates that since the uniform assessment represents an estimate of bad debt experience, once actual experience is known, the Commission will make "settle-up" adjustments in rates to correct for any error in forecasting.

Future reports will allow for a more comprehensive analysis by utilizing a full year of actual data. The HSCRC will continue to coordinate with DHMH to establish a more efficient and effective means of estimating averted bad debt resulting from the Medicaid expansion legislation, as well as determining the actual amount to be reconciled in hospital rates.

Sincerely,

Robert Murray, Executive Director
HSCRC

cc: Department of Legislative Services Library and Information Services (5 copies)
Senator Thomas Mac Middleton
Delegate Peter Hammen
Secretary John Colmers
Mr. Joseph Bryce (Governor's Legislative Office)
Ms. Marie Grant (DLS)
Ms. Linda Stahr (DLS)
Ms. Wynee Hawk (DHMH)

Appendix I

Estimate vs Actual Averted Bad Debt

Estimated for FY 2009 and FY 2010

		A Original Estimate FY 2009	B Revised Estimate FY 2009	C Revised Estimate FY 2010
1	Medicaid Total Expenditures	$95,170,624	$160,119,126	$324,422,100
2	In State Payment Percent	94.00%	94.00%	94.00%
3	In State Payments	$89,460,386	$150,511,978	$304,956,774
4	Medicaid Payment Percent	94.00%	94.00%	94.00%
5	Charges @ Hosp Payment Rate	$95,170,624	$160,119,126	$324,422,100
6	Hospital Portion	61.00%	61.00%	54.00%
7	Hospital Charges Reported	$58,054,080	$97,672,667	$175,187,934
8	Crowd Out (28%)	72.00%	72.00%	72.00%
9	Hospital Charges after Crowd	$41,798,938	$70,324,320	$126,135,312
10	Lower Use Rate	82.00%	82.00%	82.00%
11	**Averted Bad Debt**	**$34,275,129**	**$57,665,943**	**$103,430,956**
12	Medicaid Payment Percent	94.00%	94.00%	94.00%
13	Net Medicaid Payments	$32,218,621	$54,205,986	$97,225,099
14	Percent Returned to Medicaid	75.00%	75.00%	92.61%
15	Hospital Payments to Medicaid	$24,163,966	$40,654,489	$90,039,771
16	**Difference**		**$16,490,523**	
17	Settle up Payment			**$16,490,523**
18	Total Payments to Medicaid			$106,530,295

Estimated Enrollees	29,273	55,000
Cost per Enrollee per member month	$511	$539

Attachment 4

Comment letter from Calvert Memorial Hospital

Calvert Memorial Hospital
Tradition. Quality. Progress.

October 3, 2011

Stephen Ports
Acting Executive Director
Maryland Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215-2299

Dear Mr. Ports:

On behalf of Calvert Memorial Hospital [CMH], I am writing you to express our position regarding the FY 2010 Averted UCC settlement.

On January 8, 2010, we forwarded a letter to Mr. Robert Murray expressing our dissatisfaction with the UCC calculation because it disproportionately affected rural hospitals. We also reported that the UCC calculation contained numerous errors [see attached].

CMH received a 1.37% rate reduction on July 1, 2009 for the expected reduction to UCC as a result of the Medicaid Expansion Program. This reduced CMH's FY10 gross revenue by $1.6 million.

The actual regulated Medicaid expansion charges experienced by CMH in FY10 were $1.5 million. After adjusting for the impacts of crowd out and use rate, the actual averted UCC for CMH was $876,000 resulting in an amount of $739,000 due to CMH. It should be noted that of all hospitals in Maryland, CMH had the sixth highest percentage difference [0.62%] between its 2010 prospective adjustment and the 2010 actual experience.

In FY 2009, the first year of the Medicaid expansion, CMH received a small prospective rate reduction of -0.18%. The actual Medicaid Expansion charges exceeded this estimate, resulting in an amount of $236,000 due from CMH. This adjustment was applied to CMH's FY 2011 rate base. Our FY 2009 experience exceeded the prospective adjustment, similar to others in rural Maryland. This likely occurred because the enrollment of Medicaid expansion patients occurred faster in the non-urban areas.

The 2010 estimates were based on the 2009 experience. This "spread" of the estimated 2010 averted UCC overstated the prospective impact to CMH. Although CMH's

Medicaid expansion charges increased in 2010, it was far below the estimated impact since CMH experienced the 2009 expansion faster relative to other hospitals.

In regards to the crowd out and use rate assumption, the following points are made:

- These adjustments were required when determining the effect on UCC since UCC in hospital rates is based on historical information. The expansion did crowd out private insurance, and more importantly, individuals with existing Medicaid coverage. This also resulted in "new business" from expansion patients that would have avoided prior service use without coverage.

- These adjustment factors were estimates agreed to by the HSCRC Staff and Medicaid. The hospital industry believed these figures to be too low but agreed to use these figures as part of the prospective adjustment and reconciliation process. The Commission should not, under any circumstances, revise these estimates. Any reconciliation applies the same set of parameters to projected and actual information. Furthermore, Medicaid has failed to provide the HSCRC any evidence that these estimates are not reasonable.

- In its August 19, 2011 letter, Medicaid cites the crowd out assumption to be closer to 11%, which includes the crowd out of private insurance only. However, 44% of the expansion population had some form of Medicaid coverage in prior years. While not all 44% of individuals may have qualified for Medicaid without the expansion, even if one half of the 44% of previously qualified individuals would have received coverage, the 28% crowd out estimate appears valid. DHMH reviewed 100 hospital Medicaid expansion records to determine coverage eligibility in the absence of expansion. It is true that some patients would not have qualified for Medicaid without the expansion, including individuals that received coverage due to pregnancy or those that aged of SCHIP programs, etc. What is concerning is that Medicaid could not respond to 39 of the hospital records to ascertain what their coverage status would have been in the absence of expansion, nearly 40% of the total. This alone raises serious doubts regarding the integrity of the data provided by Medicaid throughout this process.

- CMH thoroughly researched the FY 2009 expansion population and found little evidence of prior service use at CMH in the expansion population. Since UCC amounts in rate rates are based on historical data, the data at CMH suggested that most of the FY 2009 expansion was for "new services."

- At a minimum, the 28% and 18% adjustments for crowd out and use rate should remain unadjusted. At CMH and other facilities, further investigation

would likely suggest that these figures are substantially higher, not lower as Medicaid asserts, since many individuals would likely have received Medicaid coverage in absence of the expansion.

In regards to the FY 2011 and FY 2012 Averted UCC impacts, CMH believes that the following is true:

- FY 2011 Averted UCC adjustments were also allocated to hospitals based on their FY 2009 preliminary experience. As discussed above, this vastly overstated the impact on CMH in FY 2010.

- Enrollment in the expansion program "ramped up" across the state in 2009 and 2010. We believe CMH's market to be at or near capacity for additional enrollment from 2011 forward. Thus if CMH was owed an amount in 2010, this should continue in 2011 and 2012.

- Based on these figures, CMH's prospective rate adjustment in 2011 was -1.23%, slightly lower than the -1.37% in 2009. Preliminary estimates reflect a -1.29% rate offset for 2012 as well. Based on our internal records, CMH still did not experience further expansion growth in 2011 and will not in 2012. This will likely result in future amounts due to CMH to settle the FY 2011 and FY 2012 prospective adjustments.

Based on these conclusions, CMH supports the HSCRC staff's Option 1 to settle the FY 2010 Averted UCC via reduced payments to Medicaid via the assessment. The payors should not be burdened with additional amounts since they have not received any additional benefit.

- The settlement amounts required should be fully applied in FY 2012 and not spread over a period of three years. To achieve the projected Averted UCC for FY 2011 on a statewide basis, Medicaid expansion charges would have to almost double from 2010 to 2011. Although we have not reviewed recent statewide trends in the expansion enrollment, it is highly improbable that enrollment would nearly double in one year, particularly if 2009 and 2010 were already the "ramp up" years. As such, an even larger settlement may be warranted for 2011 amounts. Spreading the FY 2010 amount over multiple years may only compound settlement issues for FY 2011 (and FY 2012) in the future.

- Finally, reductions to the Medicaid assessment payments must be made on a hospital specific basis to account for the settlement. Reducing the assessment

payments on a uniform basis would not appropriately address the unique impacts on each individual hospital.

I hope you will consider these facts, conclusions and recommendations at your upcoming Board meeting. As always, I appreciate your time and attention to this matter. This issue is extremely important to CMH and I hope the HSCRC supports our recommendations. I'll be happy to respond to any questions regarding the contents of this letter. Please feel free to contact me at anytime.

Sincerely

JAMES J. XINIS
President & CEO

Enclosure

cc:
Michael Robbins, MHA
Robert Kertis, VP, Finance, CMH

Calvert Memorial Hospital
Tradition. Quality. Progress.

January 8, 2010

Mr. Robert Murray
Executive Director
Maryland Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Mr. Murray:

On behalf of Calvert Memorial Hospital (CMH), I am writing you to express our concern regarding the Rate Year 2010 Uncompensated Care (UCC) funding adjustments as a result of Medicaid Expansion.

According to the schedule published by the HSCRC, CMH's FY2010 recognized UCC was reduced by 1.37% based on projected savings from Medicaid Expansion. This results in over a 20% reduction in UCC recognized (6.64% to 5.27%). While we support the value of the expanding Medicaid coverage, we believe that an adjustment of this magnitude will greatly overstate our experience in FY2010.

We have reviewed the basic Medicaid Expansion payment list, which provided the basis for the calculation. That list, totaling $829,813 was found to have a number of errors; numerous unregulated accounts listed in error and I/P and O/P reclassification errors. We believe that the total of this listing should have been $719,539.

Additionally, though we have not had sufficient time to complete the detailed patient-by-patient review, we believe that many of the patients on the list do not represent previous bad debts that are being averted.

Also, we recently received information from our local DSS that indicates new enrollments in the Medicaid program in FY2009 actually dropped in comparison to FY2008 by 2.56% despite a slight increase in applications received by 2.0%.

Furthermore, it is not appropriate to simply focus in on the Medicaid population and essentially ignore the effect that current economic conditions are having on other uncompensated care challenges. We've seen a dramatic increase in the number of consumer driven health plans with higher deductibles than the previous year.

Lastly, the impact of the new UCC calculation seems to disproportionately affect the rural hospitals. While the exact reasons are not yet known, it is interesting that those hospitals affected by more than 1.25% include:

Calvert Memorial	Easton
Western Maryland	Dorchester
Garrett	Atlantic General
Union of Cecil	Chester River

This can't be mere coincidence. We ask that this be investigated closely.

Although the HSCRC staff (and DHMH) will ultimately settle the actual experience versus the prospective rate reductions, the timing of the settlement raises cash flow concerns. According to staff policy, final settlement of FY2010 will not occur until FY2011 and will not be applied to rates until FY2012. This settlement process will directly impact CMH's profitability and cash position.

Accordingly, we do not believe the appropriate $100,000 per month increase ($165,886 versus $66,240) in CMH pool payment is warranted or justified. In addition, this increase will drive our net operating income down significantly. Instead, CMH will increase its pool payment to what it would be if we shared equally in the statewide reduction of 0.75% rather than the 1.37% disproportionately high adjustment. Our calculation of that effect is shown on the attached worksheets, using the staff's templates as a guide.

As always, we appreciate your time and attention to this matter. We would be happy to discuss the issues raised in our letter regarding the effect of Medicaid expansion on Rate Year 2010 UCC funding. Should you have any questions, please feel free to contact me.

Sincerely,

James J Xinis

JAMES J. XINIS
President & CEO

cc: Michael Robbins, MHA
David Cohen, Cohen, Rutherford + Knight
Paul Sokolowski, Interim CFO Calvert Memorial Hospital

Calvert Memorial Hospital
UCC Fund Payment Settle up

	Payment Made To/(From)	Amount Due To/(From)	(Under) Over Difference
Sept. 1, 2009	66,240	83,993	-17,753
Oct. 1, 2009	66,240	83,993	-17,753
Nov. 1, 2009	66,240	83,993	-17,753
Dec. 1, 2009	89,910	83,993	5,918
Jan. 1, 2010	89,910	83,993	5,918
Feb. 1, 2010	89,910	83,993	5,918
Mar. 1, 2010	89,910	83,993	5,918
April 1, 2010	89,910	83,993	5,918
May 1, 2010	89,910	83,993	5,918
June 1, 2010	89,910	83,993	5,918
July 1, 2010	89,910	83,993	5,918
Aug 1, 2010	89,910	83,993	5,918
	1,007,911	1,007,911	0

Additional Adjustments 09

Prior Monthly Payment	66,240
New Total Assessment	962,668
	45,243
	1,007,911

CALCULATION OF MAXIMUM UCC LEVEL
ALL UNCOMPENSATED CARE

July 1, 2009

July 1, 2009 to June 30, 2010

		July 1, 2009 REVENUE ADJ. FOR NEW MU	NEW APPROVED MARK UP	ESTIMATED APPROVED NET REVENUE	POLICY FINAL RESULT 7/01/09	NEW $ AMOUNT UCC COST	NEW UCC MAXIMUM RATE 6.83%	PERCENT DIFFERENCE -9,614,290	NEW MARK UP IN RATES (INCL MAX)	GROSS REVENUE AT NEW UCC	COLLECTED NET REV. AT NEW UCC (AD/W)	PAYMENT FROM (TO) HOSPITALS	COMBINED SCREEN A ADJUSTED N/A	% ABOVE CUTOFF 3.00%	OVERAGE PAYMENT FROM HOSPITALS	SHORTAGE-PAYMENT (TO) HOSPITALS
			W	X	Y	Z	AA	AB	AC	AD	AE	AF	AG	AH	AI	AJ
1	WASHINGTON CO.	$249,540,192	1.119775	222,848,451	6.55%	14,590,238	6.77%	0.22%	1.122520	250,151,922	223,394,748	546,297	0.00%	0.00%	546,297	0
2	UNIVERSITY OF MD.	$985,764,064	1.146396	859,880,840	8.56%	73,602,094	6.77%	-1.79%	1.123802	966,335,654	842,933,462	-16,947,379	0.00%	0.00%	0	-16,947,379
3	PRINCE GEORGES HOSP	$282,270,472	1.207862	233,694,306	13.19%	30,833,080	6.77%	-6.42%	1.122508	262,323,785	217,180,262	-16,514,045	0.00%	0.00%	0	-16,514,045
4	HOLY CROSS	$402,456,306	1.109738	362,658,774	6.30%	22,831,868	6.77%	0.47%	1.115492	404,543,076	364,539,191	1,880,417	0.00%	0.00%	1,880,417	0
5	FREDERICK MEM.	$269,176,239	1.103463	243,937,787	5.55%	13,545,411	6.77%	1.22%	1.118181	272,766,547	247,191,462	3,253,675	0.00%	0.00%	3,253,675	0
6	HARFORD MEM.	$99,016,011	1.140979	86,781,600	8.73%	7,577,278	6.77%	-1.96%	1.116492	96,891,001	84,919,156	-1,862,444	0.00%	0.00%	0	-1,862,444
7	ST. JOSEPH'S	$379,157,173	1.076350	352,262,122	3.05%	10,761,120	6.77%	3.72%	1.120250	394,621,653	366,629,648	14,367,526	0.00%	0.00%	14,367,526	0
8	MERCY	$366,351,789	1.123532	343,872,400	7.02%	24,155,587	6.77%	-0.25%	1.120392	385,271,846	342,911,197	-961,203	0.00%	0.00%	0	-961,203
9	JOHNS HOPKINS	$1,621,150,439	1.105013	1,467,087,641	5.78%	84,864,516	6.77%	0.99%	1.116932	1,638,637,136	1,482,912,525	15,824,884	0.00%	0.00%	15,824,884	0
10	DORCHESTER GEN.	$53,166,583	1.116603	47,614,593	5.46%	2,600,435	6.77%	1.31%	1.132824	53,938,954	48,306,308	691,715	0.00%	0.00%	691,715	0
11	ST. AGNES	$367,886,780	1.119487	328,620,720	6.42%	21,086,928	6.77%	0.35%	1.123842	369,317,876	329,899,069	1,278,349	0.00%	0.00%	1,278,349	0
12	SINAI	$637,224,673	1.123808	567,022,800	6.96%	39,483,168	6.77%	-0.19%	1.121421	635,871,391	565,818,607	-1,204,193	0.00%	0.00%	0	-1,204,193
13	BON SECOURS	$128,130,046	1.239001	103,413,996	14.91%	15,423,690	6.77%	-8.14%	1.127500	116,599,271	94,107,486	-9,306,510	0.00%	0.00%	0	-9,306,510
15	FRANKLIN SQUARE	$428,304,605	1.133223	377,952,527	7.53%	28,467,386	6.77%	-0.76%	1.123714	424,710,509	374,780,957	-3,171,570	0.00%	0.00%	0	-3,171,570
16	WASHINGTON ADV.	$285,998,476	1.137106	251,514,282	7.94%	19,971,747	6.77%	-1.17%	1.122464	282,315,734	248,275,586	-3,238,696	0.00%	0.00%	0	-3,238,696
17	GARRETT CO.	$38,624,014	1.109543	34,810,751	5.19%	1,807,185	6.77%	1.58%	1.128920	39,298,546	35,418,689	607,938	0.00%	0.00%	607,938	0
18	MONTGOMERY GEN.	$139,948,313	1.115626	125,443,716	6.32%	7,927,616	6.77%	0.45%	1.121146	140,640,776	126,064,410	620,694	0.00%	0.00%	620,694	0
19	PENINSULA GEN.	$378,825,277	1.103450	343,309,786	5.10%	17,503,975	6.77%	1.67%	1.123761	385,798,297	349,629,074	6,319,288	0.00%	0.00%	6,319,288	0
22	SUBURBAN	$227,512,454	1.099310	206,959,324	4.98%	10,313,833	6.77%	1.79%	1.120883	231,977,159	211,020,694	4,061,370	0.00%	0.00%	4,061,370	0
23	ANNE ARUNDEL GEN.	$383,922,692	1.088370	352,750,024	4.43%	15,642,319	6.77%	2.34%	1.116176	393,731,192	361,762,121	9,012,097	0.00%	0.00%	9,012,097	0
24	UNION MEM.	$414,932,297	1.112359	373,020,060	5.84%	21,779,754	6.77%	0.93%	1.123767	419,187,696	376,845,622	3,825,562	0.00%	0.00%	3,825,562	0
25	MEM. CUMBERLAND	$102,655,083	1.092735	93,943,255	4.13%	3,879,811	6.77%	2.64%	1.124527	105,641,761	96,676,468	2,733,214	0.00%	0.00%	2,733,214	0
27	BRADDOCK	$161,791,651	1.087229	148,810,961	3.18%	4,732,952	6.77%	3.59%	1.130465	168,225,509	154,728,625	5,917,664	0.00%	0.00%	5,917,664	0
28	ST. MARY'S	$125,984,232	1.119187	112,567,619	6.70%	7,540,826	6.77%	0.07%	1.120060	126,082,513	112,655,433	87,814	0.00%	0.00%	87,814	0
29	BAYVIEW	$524,764,932	1.138743	460,828,173	7.93%	36,565,373	6.77%	-1.16%	1.124132	518,031,671	454,915,285	-5,912,888	0.00%	0.00%	0	-5,912,888
30	CHESTER RIVER	$62,219,037	1.125269	55,292,599	6.76%	3,735,282	6.77%	0.01%	1.125449	62,228,999	55,301,452	8,853	0.00%	0.00%	8,853	0
32	UNION OF CECIL	$130,725,788	1.115734	117,165,696	6.52%	7,640,056	6.77%	0.25%	1.118784	131,083,067	117,485,914	320,218	0.00%	0.00%	320,218	0
33	CARROLL CO. GEN.	$191,119,793	1.097408	174,155,618	4.84%	8,435,751	6.77%	1.93%	1.120622	195,162,686	177,839,655	3,684,038	0.00%	0.00%	3,684,038	0
34	HARBOR HOSP.	$211,053,140	1.146570	184,073,481	8.48%	15,613,487	6.77%	-1.71%	1.124928	207,069,337	180,598,942	-3,474,540	0.00%	0.00%	0	-3,474,540
35	CIVISTA	$105,225,964	1.112409	94,592,887	6.06%	5,734,399	6.77%	0.71%	1.121059	106,044,232	95,328,469	735,582	0.00%	0.00%	735,582	0
37	MEM. EASTON	$159,526,151	1.105125	144,351,234	4.62%	6,673,455	6.77%	2.15%	1.131433	163,323,716	147,787,555	3,436,321	0.00%	0.00%	3,436,321	0
38	MARYLAND GEN.	$198,071,502	1.189500	166,516,673	11.15%	18,570,480	6.77%	-4.38%	1.131687	188,444,768	158,423,577	-8,093,096	0.00%	0.00%	0	-8,093,096
39	CALVERT MEMORIAL	$110,562,013	1.105896	99,975,045	5.89%	5,888,530	6.77%	0.88%	1.116545	111,626,624	100,937,713	962,668	0.00%	0.00%	962,668	0
40	NORTHWEST	$216,456,216	1.130381	191,489,528	7.32%	14,024,710	6.77%	-0.55%	1.123486	215,135,892	190,321,493	-1,168,035	0.00%	0.00%	0	-1,168,035
43	BALTIMORE/WASHINGTC	$313,163,009	1.119991	279,612,039	6.95%	19,421,921	6.77%	-0.18%	1.117831	312,559,136	279,072,862	-539,177	0.00%	0.00%	0	-539,177
44	G.B.M.C.	$374,157,738	1.070772	349,428,034	2.96%	10,349,225	6.77%	3.81%	1.115343	389,732,216	363,973,127	14,545,093	0.00%	0.00%	14,545,093	0
45	MCCREADY	$16,884,205	1.129991	14,941,890	6.75%	1,008,270	6.77%	0.02%	1.130267	16,888,330	14,945,541	3,651	0.00%	0.00%	3,651	0
48	HOWARD CO. GEN.	$228,955,673	1.100105	208,121,569	5.59%	11,625,310	6.77%	1.18%	1.114332	231,916,461	210,812,937	2,691,367	0.00%	0.00%	2,691,367	0
49	UPPER CHESAPEAKE	$208,684,992	1.101639	189,431,421	5.48%	10,386,317	6.77%	1.29%	1.117163	211,625,682	192,100,798	2,669,378	0.00%	0.00%	2,669,378	0
51	DR'S COMMUNITY HOSP	$194,371,404	1.142946	170,061,817	8.82%	14,992,617	6.77%	-2.05%	1.117340	190,016,835	166,251,864	-3,809,953	0.00%	0.00%	0	-3,809,953
54	SOUTHERN MD.	$230,408,030	1.133455	203,279,326	7.84%	15,945,150	6.77%	-1.07%	1.120093	227,691,802	200,882,913	-2,396,414	0.00%	0.00%	0	-2,396,414
55	LAUREL REGIONAL	$97,504,356	1.166027	83,621,009	10.45%	8,741,972	6.77%	-3.68%	1.118920	93,565,217	80,242,752	-3,378,257	0.00%	0.00%	0	-3,378,257
60	FORT WASHINGTON	$51,356,692	1.169104	43,928,262	10.90%	4,787,770	6.77%	-4.13%	1.116294	49,036,875	41,943,992	-1,984,270	0.00%	0.00%	0	-1,984,270
61	ATLANTIC GENERAL	$75,672,270	1.098166	68,907,835	4.68%	3,227,727	6.77%	2.09%	1.123384	77,409,992	70,490,220	1,582,385	0.00%	0.00%	1,582,385	0
2001	KERNANS	$106,886,587	1.110785	96,226,158	5.87%	5,651,480	6.77%	0.90%	1.121737	107,940,424	97,174,889	948,732	0.00%	0.00%	948,732	0
2004	GOOD SAMARITAN	$282,846,370	1.108169	255,237,512	5.20%	13,267,277	6.77%	1.57%	1.127416	287,758,956	259,670,577	4,433,065	0.00%	0.00%	4,433,065	0
5050	SHADY GROVE	$322,904,485	1.122567	287,648,240	7.33%	21,070,978	6.77%	-0.56%	1.115752	320,944,001	285,901,812	-1,746,428	0.00%	0.00%	0	-1,746,428
8992	SHOCK TRAUMA	$197,670,304	1.374935	143,767,033	23.85%	34,294,671	6.77%	-17.08%	1.117651	160,681,370	116,864,716	-26,902,318	0.00%	0.00%	0	-26,902,318
8994	CANCER CENTER	$58,842,165	1.176111	50,031,126	11.50%	5,752,040	6.77%	-4.73%	1.115345	55,801,963	47,446,165	-2,584,962	0.00%	0.00%	0	-2,584,962
TOTAL	- STATEWIDE	13,219,822,674	1.12284917	11,773,462,541	6.83%	804,327,065	6.77%	-0.06%	1.120877	13,196,600,053	11,765,316,019	-8,146,523			107,049,853	-115,196,376

Calvert Memorial Hospital

Summary of UCC Payment Impact

	UCC Funding	UCC in Rates	Estimated % UCC Pool (Payment) /Receipt	$ UCC Pool (Payment) / Receipt (1)
FY2010 Unadjusted Policy Result	6.64%			
Policy Increase/(Decrease)	*0.28%*			
Plus: FY2010 AVB Estimate	-0.75%			
FY2010 Provision	5.89%	6.77%	-0.88%	$ (962,668)

Attachment 5

Comment letter from MHA.

Maryland
Hospital Association

MHA
6820 Deerpath Road
Elkridge, Maryland 21075-6234
Tel: 410-379-6200
Fax: 410-379-8239

October 11, 2011

John M. Colmers
Chairman, HSCRC
Vice President, Health Care Transformation and Strategic Planning
Johns Hopkins Medicine
3910 Keswick Road, Suite N-2200
Baltimore, MD 21211

Dear Chairman Colmers:

On behalf of our 66 member organizations, I am writing to comment on the Health Services Cost Review Commission (HSCRC) staff's final presentation of options for reconciling the Fiscal Year (FY) 2010 Medicaid averted uncompensated care (UCC) estimates to actual experience. The Maryland Hospital Association (MHA) believes that the HSCRC must reduce FY 2012 planned payments to Medicaid to settle the FY 2010 overpayment. This option, Option 1, as described by the HSCRC staff, is technically correct; required by the 2008 enabling legislation; acknowledges the authority of the HSCRC to set reasonable rates; and preserves the integrity of our payment system.

At the September HSCRC public meeting, we were asked to reconsider the assumptions used to estimate the amount of UCC averted as a result of Medicaid expansion in FY 2010. HSCRC staff twice convened representatives from hospitals, Medicaid, and payors. As a result of those meetings the HSCRC now recommends reducing the crowd-out assumption from 28 percent to 18.22 percent, and leaving all other assumptions unchanged, thereby reducing the FY 2010 overestimate from $25 million to $11 million. Precisely measuring crowd out is difficult. The range of crowd out reported in published literature varies widely--from zero to more than 50 percent. The 28 percent is a credible assumption; likewise, the 18.22 percent is within a reasonable range. As a result, we believe that we can support this revised estimate for FY 2010 and would also encourage the HSCRC to adopt Option 1 as the approach to use to conclude the FY 2010 reconciliation.

MHA appreciates the opportunity to participate in the discussion of this issue. If you have any questions, concerns or would like additional information, please contact me at 410-540-5087.

Sincerely,

Traci Lynn La Valle

Traci La Valle
Vice President, Financial Policy

cc: Stephen Ports, Acting Executive Director, HSCRC
Commissioners, HSCRC

Final Staff Recommendation on QBR and MHAC Magnitudes and Scaling for the FY 2013 Update to Hospital Rates

October 12, 2011

This document represents a final amended recommendation approved by the Commission at the October 12, 2011 meeting.

Introduction

The HSCRC quality-based scaling methodologies and magnitudes "at risk" are important policy tools for providing strong incentives for hospitals to improve their quality performance over time. This document presents recommendations for the scaling magnitudes and methodologies to translate scores into rate updates for the Quality-based Reimbursement ("QBR") and Maryland Hospital Acquired Conditions ("MHACs") initiatives to be applied to FY 2013 rates based on the following hospital performance periods:

- QBR- CY 2011 (year ending December 31, 2011).
- MHAC- FY 2012 (year ending June 30, 2012).

.

Current HSCRC policy calls for the revenue neutral scaling of hospitals' position and allocation of rewards and penalties related to performance on the HCSRC's QBR and 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. The rewards (positive scaled amounts) or penalties (negative scaled amounts) are then applied to each hospital's update factor for the rate year. The total amounts scaled will be the sum of Reasonableness of Charges ("ROC"), which is ***not*** addressed in this recommendation, and Quality programs' scaling results. We also note that ROC scaling permanently impacts a hospital's revenue base, while the scaling amounts applied for Quality performance are applied on a "one-time" basis.

The reward and penalty allocations for the quality programs are computed on a "revenue neutral" basis for the system as a whole. This means that the net increases in rates for better performing hospitals is funded entirely by net decreases in rates for poorer performing hospitals.

Background

1. QBR and MHAC Measures, Scaling and Magnitude at Risk to Date

The QBR program uses the Centers for Medicare and Medicaid Services (CMS)/Joint Commission core process measures, —e.g., aspirin is given upon arrival for the patient diagnosed with heart attack--and the newly adopted for this past year "patient experience of care" or Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) measure domains.

The MHAC program currently uses 49 of the 64 Potentially Preventable Complications developed by 3M Health Information Systems, which computes actual versus expected rates of complications adjusted for each patient by the All Patient Refined Diagnosis Related Group (APR DRG) and severity of illness (SOI) category.

For FY 2012 rates, the HSCRC scaled a maximum penalty of 0.5% of base hospital revenue for the QBR (which was the same amount as FYs 2010 and 2011), and 1% for the MHAC program (which was 0.5% in FY 2011), a total of 1.5% of hospital base revenue related to quality. The final scaling magnitudes for the QBR and MHAC programs were previously determined retrospectively at the

end of a particular year because of the hospital industry's preference to see the impact of scaling on individual hospitals in the context of the overall hospital update approved by the Commission.[1]

More recently, the Maryland Hospital Association has proposed that the precise magnitude set aside for quality scaling be determined prospectively. The HSCRC staff is supportive of the prospective establishment of standards and targets.

Therefore, this recommendation for quality performance, relates to rate updates applied with FY 2013 rate orders (effective July 1, 2012).

2. *Centers for Medicare & Medicaid Services (CMS) Value Based Purchasing (VBP) Program*

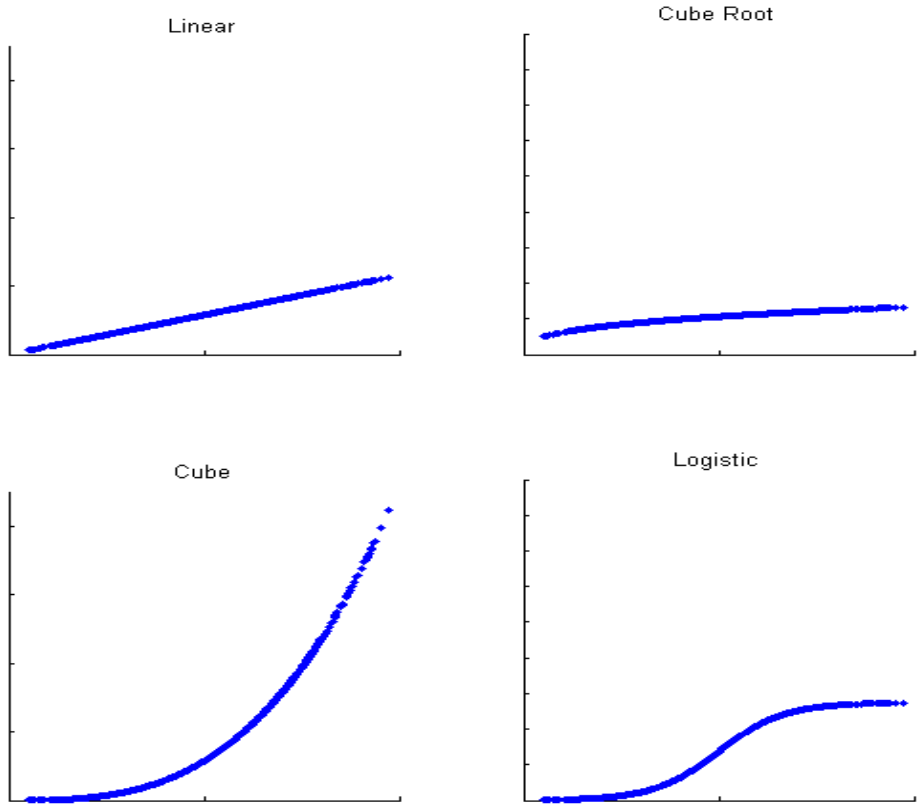
The Patient Protection and Affordable Care Act of 2010 requires CMS to fund the aggregate Hospital VBP incentive payments by reducing the base operating diagnosis-related group (DRG) payment amounts that determine the Medicare payment for each hospital inpatient discharge. The law sets the reduction at one percent in FY 2013, rising to 2 percent by FY 2017. CMS issued its VBP final rule in April 2011, the details of which are summarized below.

- ***Hospital VBP Measures-*** For the federal FY 2013 (which begins on October 1, 2012) Hospital VBP program, CMS will measure hospital performance using two domains: the clinical process of care domain and the patient experience of care domain, which is comprised of the HCAHPS survey measure.

- ***Incentive Payment Calculations-*** CMS indicates in the Final Rule that the exchange function is the means to translate a hospital's total performance score into the percentage of the value-based incentive payment earned by the hospital, and that the selection of the exact form and slope of the exchange function is of critical importance to how the incentive payments reward performance and encourage hospitals to improve the quality of care they provide. CMS considered four mathematical exchange function options: straight line (linear); concave curve (cube root function); convex curve (cube function); and S shape (logistic function) as illustrated in Figure 1 below. In evaluating each option, CMS determined that the linear function moves more aggressively to higher levels for higher performing hospitals than the cube root function, but not as aggressively as the logistic and cube functions, and that the linear exchange function ensures that all hospitals have strong incentives to continually improve the quality of care they provide to their patients. CMS indicated in the final VBP rule they may revisit the issue of the most appropriate exchange function in future rulemaking as they gain more experience under the Hospital VBP program.

[1] Note: over time, both the staff and the hospital and payer industries have suggested that the Commission consider gradually increasing the amount of revenue at risk for relative quality performance in future years.

Figure 1: Mathematical Exchanged Function Options Considered by CMS



Maryland VBP Exemption- Inpatient acute care hospitals located in the State of Maryland are not currently paid under the IPPS in accordance with a special waiver provided by section 1814(b)(3) of the Social Security Act. Despite this waiver, Maryland hospitals continue to meet the definition of a ''subsection (d) hospital" under section 1886(d)(1)(B) of the Social Security Act and are, therefore, not exempt from the CMS VBP program.

The Health and Human Services Secretary may exercise discretion pursuant to 1886(o)(1)(C)(iv) of the Social Security Act, which states that "the Secretary may exempt such hospitals from the application of this subsection if the State which is paid under such section submits an annual report to the Secretary describing how a similar program in the State for a participating hospital or hospitals achieves or surpasses the measured results in terms of patient health outcomes and cost savings established under this subsection." As a precursor to future rulemaking on this topic, CMS provides further guidance indicating that:

- The report should be received prior to the Secretary's consideration of whether to exercise discretion.
- A State shall submit, in writing and electronically, a report pursuant to section 1886(o)(1)(C)(iv) in a timeframe such that allows it to be received no later than October 1, 2011, which is the beginning of the fiscal year prior to FY 2013.
- The report should be as specific as possible in describing the quality (and other) measures included and in describing the results achieved over an applicable time

period, noting that for the initial report the applicable time period would likely be before and after implementation of the state program.

Staff notes that a VBP exemption request which included a report of Maryland's health outcomes and cost savings for the MHAC and QBR programs and a support letter from Secretary Sharfstein, was submitted to HHS Secretary Sebelius on September 30, 2011.

3. Quality Scaling Simulations

CMS has indicated its future emphasis will increasingly lean toward outcomes in the VBP program. For this reason, using this past year's performance data, staff have modeled increasing magnitudes ranging from 1% (which was used for FY 2012 rate adjustments) to 2% of total revenue in the scaling for the MHAC program, resulting in a range of ~$12.5M to ~$25M being redistributed for performance. For the QBR program, staff modeled 0.5% of revenue resulting in ~$7.5M of revenue being redistributed. A summary of the scaling amounts simulated for the MHAC and QBR programs is presented in Appendix I of this document. The MHAC simulation was discussed with MHA, hospital, and payer representatives in the September 9, 2011 Payment Work Group. The Commission will note that each magnitude scenario modeled varies in terms of the degree of scaling aggressiveness. In general, staff believes that, for the purposes of both improving quality and improving the prospect of receiving a VBP exemption, stronger incentives for improved quality are better than weaker incentives.

For the MHAC initiative, computation of the expected values for each MHAC by APR DRG and SOI cell uses the statewide average value as the benchmark for determining the expected rates. Staff notes there was discussion regarding reducing the benchmarks by 10% (to 90% of state average). However, ultimately, the Commission kept the statewide average standard for FY 2012.

As noted above, the quality scaling for each program is designed to be revenue neutral for the system as a whole. This means that the amounts allocated to better performing hospitals (rewards) must precisely match the penalties applied to poorer performing hospitals. The amount of revenue available for scaling then is a function of both a predetermined maximum amount of penalty (1% for MHAC in FY 2012) and the distribution of the hospitals on the quality index. To translate the hospitals' performance scores into rate adjustments, the scaling is linear, consistent with CMS VBP, with a maximum penalty defined by the total percentage of revenue at risk.

Staff Recommendations

For FY 2013 QBR and MHAC scaling, staff recommends:

1. Allocating 0.5% of hospital approved inpatient revenue for QBR relative performance;

2. Allocating 2.0% of hospital approved inpatient revenue for MHAC relative performance;

3. Using the linear scaling approach adopted by CMS for the VBP program for both the QBR and MHAC programs;

4. Continuing to use the statewide average as the benchmark to establish the expected MHAC values;

5. Scaling the revenue such that the maximum penalty for the poorest performing hospital is the total percent magnitude of revenue scaled for that program on a revenue neutral basis for the system; and,

6. Continuing to monitor performance of MHACs into FY 2012 and considering whether any methodology changes should be considered for FY 2014 rates. Some of the concepts raised by the Payment Work Group participants included:

    - Developing and applying an improvement factor;
    - Considering adding new/additional revenue for high performance (not maintaining revenue neutrality); and,
    - Establishing a "safe zone" for poor performing hospitals.

Appendix 1

Table 1. Summary Results of Scaling Simulations for FY 2011 MHAC Data (Benchmark=Statewide Average)
Updated October 4, 2011

Hospid	Hospital Name	Total CPC Revenue ($)	% of at Risk Revenue	Maximum Penalty of 2.00% of Hospital Inpatient CPC Revenue		Maximum Penalty of 1.75% of Hospital Inpatient CPC Revenue		Maximum Penalty of 1.50% of Hospital Inpatient CPC Revenue		Maximum Penalty of 1.00% of Hospital Inpatient CPC Revenue	
				Scaled Percent	Scaled Revenue ($)	Scaled Percent	Scaled Revenue ($)	Scaled Percent	Scaled Revenue ($)	Scaled Percent	Scaled Revenue ($)
210015	Franklin Square Hospital	251,050,912	1.60%	-2.00%	-5,021,018	-1.75%	-4,393,391	-1.50%	-3,765,764	-1.00%	-2,510,509
210003	Prince Georges Hospital	171,570,805	1.42%	-1.77%	-3,045,382	-1.55%	-2,664,709	-1.33%	-2,284,036	-0.89%	-1,522,691
210030	Chester River Hospital Center	27,448,470	1.37%	-1.71%	-470,055	-1.50%	-411,298	-1.28%	-352,541	-0.86%	-235,028
210060	Fort Washington Medical Center	22,194,884	1.14%	-1.43%	-316,277	-1.25%	-276,742	-1.07%	-237,208	-0.71%	-158,139
210057	Shady Grove Adventist Hospital	208,746,000	1.00%	-1.25%	-2,609,325	-1.09%	-2,283,159	-0.94%	-1,956,994	-0.62%	-1,304,663
210034	Harbor Hospital Center	130,564,560	0.96%	-1.20%	-1,566,775	-1.05%	-1,370,928	-0.90%	-1,175,081	-0.60%	-783,387
210032	Union Hospital of Cecil County	66,178,058	0.93%	-1.16%	-769,320	-1.02%	-673,155	-0.87%	-576,990	-0.58%	-384,660
210018	Montgomery General Hospital	90,153,792	0.82%	-1.03%	-924,076	-0.90%	-808,567	-0.77%	-693,057	-0.51%	-462,038
210016	Washington Adventist Hospital	186,493,830	0.67%	-0.84%	-1,561,886	-0.73%	-1,366,650	-0.63%	-1,171,414	-0.42%	-780,943
210051	Doctors Community Hospital	110,413,660	0.62%	-0.77%	-855,706	-0.68%	-748,743	-0.58%	-641,779	-0.39%	-427,853
210002	Univ. of Maryland Medical Center	567,218,249	0.58%	-0.73%	-4,112,332	-0.63%	-3,598,291	-0.54%	-3,084,249	-0.36%	-2,056,166
210012	Sinai Hospital	345,854,256	0.52%	-0.65%	-2,248,053	-0.57%	-1,967,046	-0.49%	-1,686,039	-0.33%	-1,124,026
210027	Western Maryland Health System	156,467,241	0.44%	-0.55%	-860,570	-0.48%	-752,999	-0.41%	-645,427	-0.28%	-430,285
210007	St. Josephs Hospital	218,909,250	0.30%	-0.38%	-820,910	-0.33%	-718,296	-0.28%	-615,682	-0.19%	-410,455
210024	Union Memorial Hospital	233,942,808	-0.03%	0.01%	28,124	0.01%	24,609	0.01%	21,093	0.01%	14,062
210023	Anne Arundel General Hospital	234,949,442	-0.24%	0.10%	225,962	0.08%	197,717	0.07%	169,472	0.05%	112,981
210054	Southern Maryland Hospital	145,187,599	-0.25%	0.10%	145,452	0.09%	127,271	0.08%	109,089	0.05%	72,726
210061	Atlantic General Hospital	35,251,727	-0.53%	0.21%	74,870	0.19%	65,511	0.16%	56,152	0.11%	37,435
210001	Meritus Medical Center	132,898,857	-0.61%	0.24%	324,864	0.21%	284,256	0.18%	243,648	0.12%	162,432
210043	Baltimore Washington Medical Cente	191,973,170	-0.67%	0.27%	515,425	0.23%	450,997	0.20%	386,569	0.13%	257,713
210055	Laurel Regional Hospital	58,282,350	-0.74%	0.30%	172,830	0.26%	151,226	0.22%	129,623	0.15%	86,415
210009	Johns Hopkins Hospital	772,947,938	-0.86%	0.34%	2,663,785	0.30%	2,330,812	0.26%	1,997,839	0.17%	1,331,893
210048	Howard County General Hospital	143,773,213	-0.89%	0.36%	512,765	0.31%	448,670	0.27%	384,574	0.18%	256,383
210005	Frederick Memorial Hospital	167,617,824	-0.97%	0.39%	651,542	0.34%	570,099	0.29%	488,657	0.19%	325,771
210022	Suburban Hospital Association,Inc	143,236,016	-1.14%	0.46%	654,346	0.40%	572,553	0.34%	490,760	0.23%	327,173
210040	Northwest Hospital Center, Inc.	123,733,548	-1.14%	0.46%	565,253	0.40%	494,596	0.34%	423,940	0.23%	282,626
210044	Greater Baltimore Medical Center	207,786,312	-1.19%	0.48%	990,865	0.42%	867,007	0.36%	743,149	0.24%	495,432
210035	Civista Medical Center	65,638,300	-1.24%	0.50%	326,159	0.43%	285,389	0.37%	244,619	0.25%	163,080
210056	Good Samaritan Hospital	188,747,898	-1.39%	0.56%	1,051,350	0.49%	919,932	0.42%	788,513	0.28%	525,675
210004	Holy Cross Hospital of Silver Spring	277,393,654	-1.56%	0.63%	1,734,090	0.55%	1,517,329	0.47%	1,300,568	0.31%	867,045
210029	Johns Hopkins Bayview Med. Center	240,870,080	-1.72%	0.69%	1,660,206	0.60%	1,452,680	0.52%	1,245,154	0.34%	830,103
210006	Harford Memorial Hospital	53,709,990	-1.73%	0.69%	372,350	0.61%	325,807	0.52%	279,263	0.35%	186,175
210013	Bon Secours Hospital	75,938,096	-1.85%	0.74%	562,966	0.65%	492,595	0.56%	422,224	0.37%	281,483
210039	Calvert Memorial Hospital	58,619,162	-1.89%	0.76%	443,968	0.66%	388,472	0.57%	332,976	0.38%	221,984
210008	Mercy Medical Center, Inc.	186,491,898	-1.95%	0.78%	1,457,287	0.68%	1,275,126	0.59%	1,092,965	0.39%	728,644
210049	Upper Chesepeake Medical Center	117,198,436	-2.02%	0.81%	948,689	0.71%	830,103	0.61%	711,517	0.40%	474,344
210019	Peninsula Regional Medical Center	244,920,000	-2.04%	0.82%	2,002,189	0.72%	1,751,915	0.61%	1,501,641	0.41%	1,001,094
210037	Memorial Hospital at Easton	89,806,444	-2.05%	0.82%	737,755	0.72%	645,535	0.62%	553,316	0.41%	368,877
210011	St. Agnes Hospital	226,412,450	-2.24%	0.90%	2,032,352	0.79%	1,778,308	0.67%	1,524,264	0.45%	1,016,176
210038	Maryland General Hospital	126,233,754	-2.37%	0.95%	1,198,876	0.83%	1,049,017	0.71%	899,157	0.47%	599,438
210033	Carroll County General Hospital	125,397,459	-2.52%	1.01%	1,266,309	0.88%	1,108,021	0.76%	949,732	0.50%	633,155
210010	Dorchester General Hospital	28,735,800	-2.73%	1.09%	314,367	0.96%	275,071	0.82%	235,775	0.55%	157,183
210028	St. Marys Hospital	59,372,280	-2.74%	1.10%	651,906	0.96%	570,418	0.82%	488,929	0.55%	325,953
210045	McCready Foundation, Inc.	4,764,618	-3.05%	1.22%	58,234	1.07%	50,955	0.92%	43,676	0.61%	29,117
210017	Garrett County Memorial Hospital	18,325,164	-3.27%	1.31%	240,130	1.15%	210,114	0.98%	180,097	0.66%	120,065
210058	James Lawrence Kernan Hospital	44,033,418	-3.38%	1.35%	596,417	1.19%	521,864	1.02%	447,312	0.68%	298,208
Statewide Total Scaled Amount					**25,181,684**		**22,033,974**		**18,886,263**		**12,590,842**

Table 2. QBR Scaling Simulation based on Clinical Process of Care (Opportunity and Appropriateness (.50/.50)) and HCAHPS CY 2010 Data Final Score: 70% Clinical Measures and 30% HCAHPS Updated on September 19, 2011					
Hospid	**Hospital Name**	**Total CPC Revenue ($)**	**Performance Score**	**Scaled Percent**	**Scaled Revenue ($)**
210027	Western Maryland Health System	156,467,241	0.2740	-0.50%	-782,336
210003	Prince Georges Hospital	171,570,805	0.2922	-0.47%	-803,847
210044	Greater Baltimore Medical Center	207,786,312	0.3734	-0.33%	-681,712
210012	Sinai Hospital	345,854,256	0.3745	-0.33%	-1,128,110
210019	Peninsula Regional Medical Center	244,920,000	0.3883	-0.30%	-740,425
210038	Maryland General Hospital	126,233,754	0.4117	-0.26%	-330,533
210005	Frederick Memorial Hospital	167,617,824	0.4399	-0.21%	-357,141
210040	Northwest Hospital Center, Inc.	123,733,548	0.4425	-0.21%	-258,073
210016	Washington Adventist Hospital	186,493,830	0.4463	-0.20%	-376,716
210055	Laurel Regional Hospital	58,282,350	0.4555	-0.19%	-108,456
210022	Suburban Hospital Association,Inc	143,236,016	0.4575	-0.18%	-261,590
210051	Doctors Community Hospital	110,413,660	0.4580	-0.18%	-200,692
210045	McCready Foundation, Inc.	4,764,618	0.4590	-0.18%	-8,578
210015	Franklin Square Hospital	251,050,912	0.4764	-0.15%	-376,426
210011	St. Agnes Hospital	226,412,450	0.4796	-0.14%	-326,952
210060	Fort Washington Medical Center	22,194,884	0.4840	-0.14%	-30,362
210057	Shady Grove Adventist Hospital	208,746,000	0.4971	-0.11%	-238,259
210054	Southern Maryland Hospital	145,187,599	0.5095	-0.09%	-134,577
210023	Anne Arundel General Hospital	234,949,442	0.5220	-0.07%	-166,985
210029	Johns Hopkins Bayview Med. Center	240,870,080	0.5223	-0.07%	-169,943
210030	Chester River Hospital Center	27,448,470	0.5302	-0.06%	-15,616
210024	Union Memorial Hospital	233,942,808	0.5495	-0.02%	-55,001
210033	Carroll County General Hospital	125,397,459	0.5752	0.02%	29,972
210056	Good Samaritan Hospital	188,747,898	0.5828	0.04%	73,434
210048	Howard County General Hospital	143,773,213	0.5853	0.04%	63,032
210002	Univ. of Maryland Medical Center	567,218,249	0.5884	0.05%	283,392
210034	Harbor Hospital Center	130,564,560	0.5942	0.06%	80,183
210013	Bon Secours Hospital	75,938,096	0.6104	0.09%	70,923
210043	Baltimore Washington Medical Center	191,973,170	0.6137	0.10%	191,801
210018	Montgomery General Hospital	90,153,792	0.6251	0.12%	110,363
210001	Meritus Medical Center	132,898,857	0.6388	0.15%	198,636
210017	Garrett County Memorial Hospital	18,325,164	0.6400	0.15%	27,824
210039	Calvert Memorial Hospital	58,619,162	0.6400	0.15%	89,003
210035	Civista Medical Center	65,638,300	0.6536	0.18%	117,284
210010	Dorchester General Hospital	28,735,800	0.6584	0.19%	54,069
210004	Holy Cross Hospital of Silver Spring	277,393,654	0.6617	0.19%	540,014
210009	Johns Hopkins Hospital	772,947,938	0.7123	0.29%	2,276,883
210061	Atlantic General Hospital	35,251,727	0.7127	0.30%	104,120
210032	Union Hospital of Cecil County	66,178,058	0.7210	0.31%	206,308
210006	Harford Memorial Hospital	53,709,990	0.7281	0.33%	174,968
210049	Upper Chesapeake Medical Center	117,198,436	0.7461	0.36%	423,439
210007	St. Josephs Hospital	218,909,250	0.7461	0.36%	790,921
210037	Memorial Hospital at Easton	89,806,444	0.7753	0.42%	376,243
210008	Mercy Medical Center, Inc.	186,491,898	0.8072	0.48%	898,756
210028	St. Mary's Hospital	59,372,280	0.8794	0.62%	370,761
Statewide Total Scaled Amount					**7,552,330**

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

John M. Colmers
Chairman

Joseph R. Antos, Ph.D.

George H. Bone, M.D.

Jack C. Keane

Bernadette C. Loftus, M.D

Thomas R. Mullen

Herbert S. Wong, Ph.D.

HEALTH SERVICES COST REVIEW COMMISSION
4160 Patterson Avenue, Baltimore, Maryland 21215
Phone: 410-764-2605 · Fax: 410-358-6217
Toll Free: 1-888-287-3229
www.hscrc.state.md.us

Stephen Ports
Acting Executive Director

Gerard J. Schmith
Deputy Director
Hospital Rate Setting

Mary Beth Pohl
Deputy Director
Research and Methodology

TO: Commissioners

FROM: Legal Department

DATE: October 5, 2011

RE: Hearing and Meeting Schedule

Public Session:

November 2, 2011 Time to be determined, 4160 Patterson Avenue, HSCRC Conference Room

December 8, 2011 Time to be determined, 4160 Patterson Avenue, HSCRC Conference Room

Please note, Commissioner packets will be available in the Commission's office at 9:00 a.m.

The Agenda for the Executive and Public Sessions will be available for your review on the Thursday before the Commission meeting at the Commission's website.
http://www.hscrc.state.md.us/CommissionMeetingSchedule.cfm

Post-meeting documents will be available on the Commission's website following the Commission meeting.