A Revision of the Uncompensated Care Methodology

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

May 2, 2007

This recommendation was approved by the Commission on 05/02/07.

Introduction

The system's provision for uncompensated care is one of the hallmarks of rate regulation in Maryland. Uncompensated care includes bad debt and charity care. By recognizing reasonable levels of bad debt and charity care in hospital rates, the system enhances access to hospital care for those citizens who cannot pay for care.

In April 2006, the Commission approved a new regression methodology for calculating the level of uncompensated care built into rates for Maryland hospitals. Prior to the adoption of this new methodology, the staff received several comment letters suggesting an alternative formulation of the regression to incorporate outpatient information, particularly from the emergency room. There was considerable discussion regarding this issue and the potential for future modifications to incorporate some outpatient measures of uncompensated care.

Over the past few months the Financial Technical Issues Task Force has worked with Commission staff on a broad range of possible measures that can be used in calculating the level of uncompensated care built into rates for Maryland hospitals. The group completed its work in January 2007.

Purpose

The purpose of this proposal is to incorporate the Task Force's recommended measures of uncompensated care into the methodology used in calculating the level of uncompensated care built into rates. The new regression methodology uses four new independent variables instead of the two independent variables (the proportion of a hospital's days from Medicaid, self-pay, and charity, and the proportion of a hospital's days from non-Medicare admissions through the emergency room) used in the current methodology. The four variables in the new methodology are: (1) the proportion of a hospital's total charges from inpatient Medicaid, self-pay and charity; (2) the proportion of a hospital's total charges from inpatient non-Medicare admissions through the emergency room; (3) the proportion of a hospital's total charges from outpatient Medicaid, self-pay, and charity visits to the emergency room; and (4) the proportion of a hospital's total charges from outpatient services. All the variables are based on hospital's gross revenue.

Model

The model remains as specified in the current methodology while incorporating the new variables. The amount of uncompensated care in rates would be computed as follows:

1. Compute a three-year moving average for uncompensated care for each hospital.
2. Use the most recent three years of data to compute the uncompensated care regression (while adding dummy variables for each year).
3. Generate a predicted value for the hospital's uncompensated care rate based on the last available year of data.

4. Compute a 50/50 blend of the predicted and three-year moving average as the hospital's amount in rates.
5. Calculate the statewide amount of uncompensated care in rates from this procedure, and generate the percentage difference between the preliminary amount in rates and the last year of actual experience.
6. Add/subtract the statewide difference (step 5) to the hospital's preliminary UCC rate (step 4) to get adjusted rates that tie to the State's last year of actual UCC experience. This result is the hospital's UCC rate for the next fiscal year.

Medicaid Day Limits

The above steps describe the general policy, but the procedure is silent on the treatment of Medicaid day limits. While day limits are in effect, the most straightforward procedure is to remove the pre-funded amounts in rates for day limits from the actual uncompensated care prior to calculating the model described above. The pre-funded amounts will then be added to the UCC rate calculated in step 6 to finance the day limits portion separately, which would end when the day limits policy ends.

Result

The result of this approach is that the prospective amount built into rates across the industry is the amount actually experienced in the last year of available data. If, for example, uncompensated care were $723 million in FY06, this model would establish rates that would deliver $723 million in FY08 if volumes and rates remain the same.

Exhibit 1 shows the results of preliminary calculation of uncompensated care rates for FY2008 under this proposed methodology. Exhibit 2 provides a summary of the preliminary results from the model. Exhibit 3 provides a statistical summary of the data elements and regression results of the current and the proposed methodologies. Exhibit 4 shows the difference in uncompensated care rates by comparing the results of the current and the proposed methodologies by hospital.

This approach is considered to be an improvement to the current methodology, conceptually, statistically, and analytically. It maintains the responsiveness to actual uncompensated care in the system that was introduced by the current methodology and also preserves the incentives for hospitals to improve credit and collection activities. This results in an improved distribution of revenue within the rate-setting system over time based on hospitals' overall experience.

The final results of this change in the method for calculating uncompensated care will be published when the financial data from all hospitals become available by the end of May 2007.

Comments

Letters were received by Commission staff from hospitals commenting on the proposed recommendation. Most of the responses were in favor of the proposal. There were two unfavorable responses.

One response in particular suggested postponing the inclusion of outpatient variables in calculating uncompensated care to be built into rates until the data can be studied and the complete outpatient data can be used in constructing the variables. This issue among others was discussed at length at the meetings of the MHA Financial Technical Issues Task Force. While it was acknowledged that there are inconsistencies across hospitals in reporting the outpatient data, the consensus was that its impact on the method for calculating uncompensated care is negligible and that the complete outpatient data set is scheduled to be collected effective July 1, 2007.

The letters containing hospitals' comments are provided in the appendix.

Recommendation

The staff recommends that the Commission incorporate the new variables in the calculation of prospective levels of uncompensated care for Maryland hospitals. The method described in the "Model" section of this paper would be used to establish the uncompensated care provision for Maryland acute care hospitals, effective July 1, 2007.

EXHIBIT

EXHIBIT 1

Policy Results from the Regression, Revenue Neutrality, and Adjustment for Medicaid Day Limit for FY 2008

Hospid	Hospital Name	UCC in Rates (Without MDL)	UCC in Rates	Actual UCC (Without MDL)	Predicted UCC	FY '04 - FY '06 UCC AVERAGE	50/ 50 BLENDED UCC AVERAGE	Revenue Neutrality Adjustment	Policy Results	* New Medicaid Day Limit Add-on	Policy Results Adjusted for Medicaid Day Limit Add-on
210001	Washington County Hospital	6.15%	6.51%	7.21%	6.78%	6.93%	6.86%	0.17%	7.02%	0.36%	7.38%
210002	Univ. of Maryland Medical System	9.64%	10.53%	10.01%	8.68%	9.39%	9.03%	0.17%	9.20%	0.89%	10.09%
210003	Prince Georges Hospital	12.79%	14.60%	12.72%	12.36%	13.56%	12.96%	0.17%	13.13%	1.81%	14.94%
210004	Holy Cross Hospital of Silver Spring	5.93%	6.54%	6.38%	7.01%	6.07%	6.54%	0.17%	6.71%	0.61%	7.32%
210005	Frederick Memorial Hospital	5.47%	5.68%	5.24%	5.60%	5.02%	5.31%	0.17%	5.48%	0.21%	5.69%
210006	Harford Memorial Hospital	7.75%	7.84%	9.08%	8.15%	9.08%	8.62%	0.17%	8.78%	0.09%	8.87%
210007	St. Josephs Hospital	3.18%	3.60%	2.20%	2.92%	2.42%	2.67%	0.17%	2.84%	0.42%	3.26%
210008	Mercy Medical Center, Inc.	8.63%	8.90%	8.44%	7.84%	8.63%	8.23%	0.17%	8.40%	0.27%	8.67%
210009	Johns Hopkins Hospital	6.77%	7.56%	5.95%	6.63%	5.60%	6.11%	0.17%	6.28%	0.79%	7.07%
210010	Dorchester General Hospital	8.07%	8.92%	8.63%	8.43%	8.53%	8.48%	0.17%	8.65%	0.85%	9.50%
210011	St. Agnes Hospital	6.93%	7.55%	6.80%	7.41%	6.79%	7.10%	0.17%	7.27%	0.62%	7.89%
210012	Sinai Hospital	7.06%	7.47%	8.12%	7.24%	7.59%	7.42%	0.17%	7.58%	0.41%	7.99%
210013	Bon Secours Hospital	11.87%	13.43%	14.08%	12.98%	12.52%	12.75%	0.17%	12.92%	1.56%	14.48%
210015	Franklin Square Hospital	7.26%	7.65%	8.23%	7.97%	7.65%	7.81%	0.17%	7.98%	0.39%	8.37%
210016	Washington Adventist Hospital	6.84%	7.39%	7.01%	6.30%	6.80%	6.55%	0.17%	6.71%	0.55%	7.26%
210017	Garrett County Memorial Hospital	6.02%	6.06%	6.76%	7.41%	5.95%	6.68%	0.17%	6.85%	0.04%	6.89%
210018	Montgomery General Hospital	6.32%	6.82%	7.37%	6.31%	6.39%	6.35%	0.17%	6.51%	0.50%	7.01%
210019	Peninsula Regional Medical Center	5.64%	5.92%	6.30%	5.61%	5.74%	5.68%	0.17%	5.84%	0.28%	6.12%
210022	Suburban Hospital Association,Inc	5.03%	5.29%	4.89%	4.94%	4.36%	4.65%	0.17%	4.82%	0.26%	5.08%
210023	Anne Arundel General Hospital	4.52%	4.73%	4.90%	4.62%	4.45%	4.54%	0.17%	4.70%	0.21%	4.91%
210024	Union Memorial Hospital	7.04%	7.72%	7.48%	6.47%	7.42%	6.94%	0.17%	7.11%	0.68%	7.79%
210025	The Memorial Hospital	4.69%	4.78%	4.00%	6.34%	4.06%	5.20%	0.17%	5.36%	0.09%	5.45%
210027	Sacred Heart Hospital	4.70%	4.96%	4.22%	4.41%	4.06%	4.23%	0.17%	4.40%	0.26%	4.66%
210028	St. Marys Hospital	6.15%	6.45%	4.89%	7.47%	5.02%	6.25%	0.17%	6.41%	0.30%	6.71%
210029	Johns Hopkins Bayview Med. Center	9.80%	11.34%	9.75%	8.14%	9.88%	9.01%	0.17%	9.18%	1.54%	10.72%
210030	Kent & Queen Annes Hospital	6.55%	6.59%	8.11%	5.50%	7.99%	6.74%	0.17%	6.91%	0.04%	6.95%
210032	Union Hospital of Cecil County	6.97%	7.70%	8.02%	7.96%	6.85%	7.41%	0.17%	7.58%	0.73%	8.31%
210033	Carroll County General Hospital	5.45%	5.68%	4.24%	5.73%	4.57%	5.15%	0.17%	5.31%	0.23%	5.54%
210034	Harbor Hospital Center	8.08%	9.06%	9.20%	9.32%	8.72%	9.02%	0.17%	9.18%	0.98%	10.16%
210035	Civista Medical Center	6.50%	7.37%	5.26%	7.24%	5.61%	6.43%	0.17%	6.59%	0.87%	7.46%
210037	Memorial Hospital at Easton	6.25%	6.50%	5.28%	6.75%	6.29%	6.52%	0.17%	6.68%	0.25%	6.93%
210038	Maryland General Hospital	9.12%	11.19%	11.28%	12.12%	9.51%	10.82%	0.17%	10.98%	2.07%	13.05%
210039	Calvert Memorial Hospital	6.31%	6.53%	5.91%	5.86%	5.81%	5.83%	0.17%	6.00%	0.22%	6.22%
210040	Northwest Hospital Center, Inc.	6.48%	6.78%	8.15%	6.78%	7.28%	7.03%	0.17%	7.20%	0.30%	7.50%
210043	North Arundel General Hospital	6.36%	6.61%	6.84%	6.51%	6.03%	6.27%	0.17%	6.44%	0.25%	6.69%
210044	Greater Baltimore Medical Center	3.34%	3.37%	2.64%	3.76%	2.73%	3.25%	0.17%	3.41%	0.03%	3.44%
210045	McCready Foundation, Inc.	7.09%	7.32%	6.38%	7.31%	7.59%	7.45%	0.17%	7.62%	0.23%	7.85%
210048	Howard County General Hospital	5.37%	5.75%	5.28%	6.42%	4.99%	5.70%	0.17%	5.87%	0.38%	6.25%
210049	Upper Chesepeake Medical Center	5.95%	5.99%	5.23%	6.42%	5.46%	5.94%	0.17%	6.11%	0.04%	6.15%
210051	Doctors Community Hospital	7.28%	7.55%	8.54%	7.37%	7.67%	7.52%	0.17%	7.69%	0.27%	7.96%
210054	Southern Maryland Hospital	6.16%	6.48%	6.36%	6.95%	6.42%	6.69%	0.17%	6.86%	0.32%	7.18%
210055	Laurel Regional Hospital	9.15%	10.16%	11.13%	9.20%	11.68%	10.44%	0.17%	10.61%	1.01%	11.62%
210056	Good Samaritan Hospital	6.32%	7.29%	6.39%	6.06%	6.69%	6.38%	0.17%	6.54%	0.97%	7.51%
210057	Shady Grove Adventist Hospital	5.79%	6.15%	6.52%	6.69%	6.26%	6.47%	0.17%	6.64%	0.36%	7.00%
** 210058	James Lawrence Kernan Hospital	7.06%	7.06%	5.50%	0.00%	6.61%	5.50%	0.00%	5.50%	0.00%	5.50%
210060	Fort Washington Medical Center	8.70%	9.06%	8.73%	8.11%	9.22%	8.66%	0.17%	8.83%	0.36%	9.19%
210061	Atlantic General Hospital	5.37%	5.69%	5.75%	5.82%	5.60%	5.71%	0.17%	5.88%	0.32%	6.20%
	STATE-WIDE	6.88%	7.47%	7.01%	6.90%	6.76%	6.85%	0.17%	7.01%	0.60%	7.61%

* ***New Medicaid Day Limit Add-on effective July 2006***

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

EXHIBIT 2

Preliminary Results of the UCC Model for FY 2008

Hospid	Hospital Name	UCC Rate for FY 2008
210001	Washington County Hospital	7.38%
210002	Univ. of Maryland Medical System	10.09%
210003	Prince Georges Hospital	14.94%
210004	Holy Cross Hospital of Silver Spring	7.32%
210005	Frederick Memorial Hospital	5.69%
210006	Harford Memorial Hospital	8.87%
210007	St. Josephs Hospital	3.26%
210008	Mercy Medical Center, Inc.	8.67%
210009	Johns Hopkins Hospital	7.07%
210010	Dorchester General Hospital	9.50%
210011	St. Agnes Hospital	7.89%
210012	Sinai Hospital	7.99%
210013	Bon Secours Hospital	14.48%
210015	Franklin Square Hospital	8.37%
210016	Washington Adventist Hospital	7.26%
210017	Garrett County Memorial Hospital	6.89%
210018	Montgomery General Hospital	7.01%
210019	Peninsula Regional Medical Center	6.12%
210022	Suburban Hospital Association,Inc	5.08%
210023	Anne Arundel General Hospital	4.91%
210024	Union Memorial Hospital	7.79%
210025	The Memorial Hospital	5.45%
210027	Sacred Heart Hospital	4.66%
210028	St. Marys Hospital	6.71%
210029	Johns Hopkins Bayview Med. Center	10.72%
210030	Kent & Queen Annes Hospital	6.95%
210032	Union Hospital of Cecil County	8.31%
210033	Carroll County General Hospital	5.54%
210034	Harbor Hospital Center	10.16%
210035	Civista Medical Center	7.46%
210037	Memorial Hospital at Easton	6.93%
210038	Maryland General Hospital	13.05%
210039	Calvert Memorial Hospital	6.22%
210040	Northwest Hospital Center, Inc.	7.50%
210043	North Arundel General Hospital	6.69%
210044	Greater Baltimore Medical Center	3.44%
210045	McCready Foundation, Inc.	7.85%
210048	Howard County General Hospital	6.25%
210049	Upper Chesepeake Medical Center	6.15%
210051	Doctors Community Hospital	7.96%
210054	Southern Maryland Hospital	7.18%
210055	Laurel Regional Hospital	11.62%
210056	Good Samaritan Hospital	7.51%
210057	Shady Grove Adventist Hospital	7.00%
* 210058	James Lawrence Kernan Hospital	5.50%
210060	Fort Washington Medical Center	9.19%
210061	Atlantic General Hospital	6.20%
	STATE-WIDE	7.61%

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

EXHIBIT 3

Statistical Summary of the Data Elements and Regression Results

Proposed Methodology

R-Square	0.6686
Adjusted R-Square	0.6534

Variables:	Parameter Estimate	Standard Error	t Value	P-Value (Pr > |t|)
The proportion of a hospital's total charges from inpatient non-Medicare admissions through the emergency room	0.12345	0.03366	3.67	0.0004
The proportion of a hospital's total charges from inpatient Medicaid, self-pay and charity	0.21833	0.02665	8.19	<0.0001
The proportion of a hospital's total charges from outpatient Medicaid, self-pay, and charity visits to the emergency room	0.42201	0.09804	4.30	<0.0001
The proportion of a hospital's total charges from outpatient services	0.04452	0.02227	2.00	0.0476

Current Methodology

R-Square	0.6065
Adjusted R-Square	0.5947

Variables:	Parameter Estimate	Standard Error	t Value	P-Value (Pr > |t|)
The proportion of a hospital's days from non-Medicare admissions through the emergency room	0.13839	0.02225	6.22	<0.0001
The proportion of a hospital's days from Medicaid, self-pay, and charity	0.13852	0.01441	9.61	<0.0001

EXHIBIT 4
Comparison of the Results of Proposed and Current Methodologies for FY 2008

Hospid	Hospital Name	UCC Rate (Proposed)	UCC Rate (Current)	Difference
210001	Washington County Hospital	7.38%	6.75%	0.63%
210002	Univ. of Maryland Medical System	10.09%	10.80%	-0.72%
210003	Prince Georges Hospital	14.94%	14.98%	-0.05%
210004	Holy Cross Hospital of Silver Spring	7.32%	6.91%	0.41%
210005	Frederick Memorial Hospital	5.69%	5.43%	0.25%
210006	Harford Memorial Hospital	8.87%	8.39%	0.48%
210007	St. Josephs Hospital	3.26%	3.52%	-0.27%
210008	Mercy Medical Center, Inc.	8.67%	8.92%	-0.25%
210009	Johns Hopkins Hospital	7.07%	7.47%	-0.40%
210010	Dorchester General Hospital	9.50%	8.77%	0.73%
210011	St. Agnes Hospital	7.89%	7.54%	0.35%
210012	Sinai Hospital	7.99%	7.67%	0.32%
210013	Bon Secours Hospital	14.48%	13.99%	0.48%
210015	Franklin Square Hospital	8.37%	8.11%	0.26%
210016	Washington Adventist Hospital	7.26%	7.48%	-0.21%
210017	Garrett County Memorial Hospital	6.89%	6.04%	0.85%
210018	Montgomery General Hospital	7.01%	7.27%	-0.26%
210019	Peninsula Regional Medical Center	6.12%	6.29%	-0.17%
210022	Suburban Hospital Association,Inc	5.08%	5.50%	-0.42%
210023	Anne Arundel General Hospital	4.91%	4.78%	0.13%
210024	Union Memorial Hospital	7.79%	8.00%	-0.22%
210025	The Memorial Hospital	5.45%	4.62%	0.84%
210027	Sacred Heart Hospital	4.66%	4.98%	-0.32%
210028	St. Marys Hospital	6.71%	6.66%	0.05%
210029	Johns Hopkins Bayview Med. Center	10.72%	11.48%	-0.76%
210030	Chester River Hospital Center	6.95%	6.60%	0.35%
210032	Union Hospital of Cecil County	8.31%	7.69%	0.62%
210033	Carroll County General Hospital	5.54%	5.49%	0.05%
210034	Harbor Hospital Center	10.16%	9.48%	0.69%
210035	Civista Medical Center	7.46%	7.07%	0.40%
210037	Memorial Hospital at Easton	6.93%	6.47%	0.46%
210038	Maryland General Hospital	13.05%	11.96%	1.09%
210039	Calvert Memorial Hospital	6.22%	6.36%	-0.14%
210040	Northwest Hospital Center, Inc.	7.50%	7.19%	0.31%
210043	Baltimore Washington Medical Center	6.69%	6.53%	0.16%
210044	Greater Baltimore Medical Center	3.44%	3.32%	0.13%
210045	McCready Foundation, Inc.	7.85%	6.73%	1.12%
210048	Howard County General Hospital	6.25%	6.02%	0.24%
210049	Upper Chesepeake Medical Center	6.15%	5.88%	0.27%
210051	Doctors Community Hospital	7.96%	8.13%	-0.17%
210054	Southern Maryland Hospital	7.18%	6.89%	0.29%
210055	Laurel Regional Hospital	11.62%	10.66%	0.96%
210056	Good Samaritan Hospital	7.51%	7.48%	0.03%
210057	Shady Grove Adventist Hospital	7.00%	6.58%	0.42%
210058	James Lawrence Kernan Hospital	5.50%	5.50%	0.00%
210060	Fort Washington Medical Center	9.19%	8.66%	0.53%
210061	Atlantic General Hospital	6.20%	5.63%	0.57%
	STATE-WIDE	7.61%	7.61%	0.00%

APPENDIX

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JOHNS HOPKINS
MEDICINE
JOHNS HOPKINS
HEALTH SYSTEM

April 19, 2007

Mr. Nduka Udom
Associate Director, Research & Methodology
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Andy,

On behalf of the Johns Hopkins Health System member hospitals, I am writing to comment on the recently proposed changes to the Uncompensated Care Policy (UCC). While we agree that there is a need to capture outpatient activity in the UCC regression, we feel that at this point there are still many issues with the data set and that the resulting amounts do not make logical sense.

Under the proposed methodology the Ambulatory Care and Ambulatory Surgery Data Tapes are used to capture the "poor" Emergency Department outpatient cases. We do not feel that this adequately captures the true outpatient poor population for many hospitals. At Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center we have very large outpatient psychiatry clinics which carry a very high percentage of poor patients which do not get picked up in the regression. Currently under the Ambulatory Care Data Tape definition, these cases are not captured. Under the new proposed full outpatient data set scheduled for July 1, 2007 effective date, these cases would be picked up as well as other outpatient clinic cases which at the urban hospitals serve for many as primary care provider sites. This is even further exacerbated by the fact that the denominator is total outpatient revenue. Furthermore there is currently not a reconciliation process in place to assure that all outpatient revenues are being properly reported on the data tapes.

In addition to the issues concerning the outpatient data tapes, the results of the new methodology don't seem to make logical sense. Currently there are 19 hospitals who have more UCC in rates than they have actual UCC cost, under the proposed methodology this increases to 25 hospitals where UCC will be overfunded. In addition 11 of the original 19 hospitals that are over funded become even more over funded under the proposed methodology. Several hospitals who have an unfavorable variance between UCC in Rates and Actual UCC within 0.1% end up under the proposed methodology of being under funded by more than 0.5%.

While we support the use of an outpatient variable in the UCC calculation, we feel that the results of the proposed methodology are counter intuitive to actual UCC experience. It is for this and the other reasons mentioned above that we would suggest postponing the

adoption of the outpatient variables until the data can be studied further and the complete outpatient data tape can be utilized.

Sincerely,

Ed Beranek
Director of Regulatory Compliance

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April 25, 2007

Mr. Nduka Udom
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Andy:

This letter is intended to serve as public comment, on behalf of Mercy Medical Center, regarding the draft proposal "A Revision of the Uncompensated Care Methodology" dated April 11, 2007.

Mercy Medical Center agrees with the concept behind the proposed revision to the Uncompensated Care (UCC) methodology, meaning the incorporation of an outpatient statistic as a measure of UCC. However, we feel too much emphasis was placed on improving the R-squared value and not enough on the analytics of the output of the formulas.

Although there are some statistical concerns (like the P-value of the outpatient statistic), I think the more concerning points are illustrated in the results. Below are several points to illustrate our concerns.

1. As shown in the attachment, there are a large number of hospitals that have undesirable results. The attachment compares the current over or under funding of UCC to the change in the predicted value. The over or under funding is based on the amount currently in rates compared to the three year actual UCC. The hope would be that hospitals that are under-funded receive an increase in the predicted value and vice versa. This is not the case in over 40% of the hospitals.
2. There is no notable improvement in the number of hospitals or variation in hospitals that are over or under funded.

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3. Specific hospital examples of unexpected and unanticipated results are (all with similar service areas):

    a. Mercy – historically stable amount of UCC and funding levels have been appropriate. Proposed policy reduces the predicted value well below actual. Although the blending helps to mitigate the negative impact this year, the lower predicted value will continue to play through in future years.
    b. University of Maryland – current funding close to actual results and the predicted value is reduced by almost 2%. Again, only a portion flows through in this year, but the impact will continue in future years.
    c. Union Memorial – currently under-funded and predicted value is reduced by almost 1%
    d. Johns Hopkins Bayview – funded at or near actual and the predicted value is reduced by almost 2%.

There are many other examples that could be pointed out, many going in the opposite direction.

This proposal is a material change to the UCC policy and it is important to show considerable improvement before approving such a change. It is also important to separate the other policy decisions like blending the regression results with actual UCC. The true impact of the proposal will play out over several years and will be more than what is shown in the current year results.

Thank you for considering these comments. Please call me at (410) 659-2905 if you have any questions or need additional information.

Sincerely,

Justin Deibel
VP Clinical Economics

Mercy Medical Center

UCC Results - 2007 Policy & Proposed Changes

For Rate Year 2008

ID	Hospital	{A} FY 2006 Revenue	{B} UCC Currently In Rates (1)	{C} Actual 3 Year Avg. UCC (1)	{D=B-C} Over/ (Under) Funding	{E} Change in Predicted Value (1)	{F=D+E} Total Impact	{G} Subjective Analytics (2)
210001	Washington County Hospital	$190,943,600	6.16%	6.93%	-0.77%	0.87%	0.09%	Good
210002	**University of Maryland Hospital**	**760,193,400**	**9.64%**	**9.50%**	**0.14%**	**-1.72%**	**-1.59%**	**Bad**
210003	Prince Georges Hospital Center	239,399,600	12.79%	13.56%	-0.77%	-0.47%	-1.23%	Bad
210004	Holy Cross Hospital	333,999,100	5.93%	6.07%	-0.14%	0.43%	0.28%	Good
210005	Frederick Memorial Hospital	196,272,600	5.48%	5.02%	0.46%	0.08%	0.54%	Bad
210006	Harford Memorial Hospital	64,204,000	7.75%	9.28%	-1.53%	0.62%	-0.90%	Maybe
210007	St. Joseph Medical Center	342,591,900	3.18%	2.42%	0.76%	-0.95%	-0.19%	Good
210008	**Mercy Medical Center**	**292,129,600**	**8.64%**	**8.63%**	**0.01%**	**-0.77%**	**-0.76%**	**Bad**
210009	Johns Hopkins Hospital	1,322,871,800	6.77%	5.60%	1.17%	-1.15%	0.02%	Good
210010	Dorchester General Hospital	42,535,500	8.08%	8.53%	-0.45%	1.17%	0.71%	Maybe
210011	St. Agnes Hospital	311,350,800	6.94%	6.79%	0.15%	0.35%	0.51%	Bad
210012	Sinai Hospital	514,199,200	7.06%	7.59%	-0.53%	0.30%	-0.23%	Good
210013	Bon Secours Hospital	87,454,500	11.88%	11.37%	0.51%	0.65%	1.16%	Bad
210015	Franklin Square Hospital Center	337,909,200	7.26%	7.65%	-0.39%	0.16%	-0.23%	Good
210016	Washington Adventist Hospital	250,370,716	6.84%	6.43%	0.41%	-0.81%	-0.40%	Good
210017	Garrett County Memorial Hospital	30,971,400	6.02%	5.95%	0.07%	1.35%	1.42%	Bad
210018	Montgomery General Hospital	106,766,600	6.32%	6.39%	-0.07%	-0.91%	-0.98%	Bad
210019	Peninsula Regional Medical Center	308,930,400	5.65%	5.74%	-0.09%	-0.73%	-0.82%	Bad
210022	Suburban Hospital	178,949,700	5.03%	4.36%	0.67%	-1.26%	-0.58%	Maybe
210023	Anne Arundel Medical Center	298,002,100	4.52%	4.45%	0.07%	-0.14%	-0.08%	Good
210024	**Union Memorial Hospital**	**332,271,100**	**7.04%**	**7.42%**	**-0.38%**	**-0.80%**	**-1.18%**	**Bad**
210025	Memorial of Cumberland	95,983,600	4.69%	4.06%	0.63%	1.24%	1.88%	Bad
210027	Sacred Heart Hospital	129,680,100	4.70%	4.06%	0.64%	-1.05%	-0.41%	Good
210028	St. Mary's Hospital	97,642,200	6.15%	5.02%	1.13%	-0.26%	0.87%	Maybe
210029	**Johns Hopkins Bayview Medical Center**	**397,048,800**	**9.81%**	**9.88%**	**-0.07%**	**-1.83%**	**-1.90%**	**Bad**
210030	Chester River Hospital Center	52,086,800	6.54%	7.99%	-1.45%	0.32%	-1.12%	Maybe
210032	Union of Cecil	94,968,500	6.97%	7.08%	-0.11%	0.89%	0.78%	Maybe
210033	Carroll County General Hospital	153,454,534	5.45%	4.57%	0.88%	-0.29%	0.59%	Maybe
210034	Harbor Hospital Center	162,229,300	8.08%	8.72%	-0.64%	1.03%	0.39%	Good
210035	Civista Medical Center	80,852,800	6.50%	5.61%	0.89%	0.41%	1.30%	Bad
210037	Memorial Hospital at Easton	118,724,600	6.26%	6.29%	-0.03%	0.56%	0.53%	Bad
210038	Maryland General Hospital	163,918,900	9.12%	9.51%	-0.39%	1.87%	1.47%	Maybe
210039	Calvert Memorial Hospital	88,535,500	6.32%	5.81%	0.51%	-0.68%	-0.16%	Good
210040	Northwest Hospital Center	175,332,500	6.48%	7.28%	-0.80%	0.27%	-0.54%	Maybe
210043	Baltimore Washington Medical Center	239,891,800	6.36%	6.23%	0.13%	-0.08%	0.06%	Good
210044	GBMC	331,087,800	3.34%	2.73%	0.61%	-0.18%	0.43%	Good
210045	McCready Memorial Hospital	13,783,200	7.09%	7.59%	-0.50%	1.90%	1.41%	Maybe
210048	Howard County General Hospital	171,738,700	5.37%	4.99%	0.38%	0.07%	0.46%	Bad
210049	Upper Chesapeake Medical Center	137,071,200	5.96%	5.61%	0.35%	0.14%	0.50%	Bad
210051	Doctors Community Hospital	150,515,400	7.28%	7.67%	-0.39%	-0.72%	-1.11%	Bad
210054	Southern Maryland Hospital Center	177,273,500	6.16%	6.07%	0.09%	0.21%	0.29%	Bad
210055	Laurel Regional Hospital	79,611,000	9.16%	11.68%	-2.52%	1.57%	-0.95%	Maybe
210056	Good Samaritan Hospital	230,371,900	6.32%	6.69%	-0.37%	-0.32%	-0.69%	Bad
210057	Shady Grove Adventist Hospital	256,006,520	5.79%	5.97%	-0.18%	0.41%	0.23%	Good
210060	Fort Washington Medical Center	36,311,920	8.70%	9.73%	-1.03%	0.69%	-0.33%	Good
210061	Atlantic General Hospital	54,654,300	5.37%	5.60%	-0.23%	0.74%	0.51%	Maybe
		$10,231,092,190	6.87%	6.75%	0.13%	-0.37%	-0.24%	

Good	*32.6%*	15
Bad	*41.3%*	19
Maybe	*26.1%*	12

Note (1): Change in predicted value is the difference between the current policy predicted value and the proposed methodology predicted value.
Note (2): A "Maybe" result indicates that the direction may be correct, but the adjustment is more than 0.5% exaggerated.

Good = Underfunded in rates & reasonable increase in Predicted Value.
Overfunded in rates & reasonable decrease in Predicted Value.

Bad = Underfunded in rates & decrease in Predicted Value.
Overfunded in rates & increase in Predicted Value.
Extreme variances in Predicted Value relative to over/under funding.

GBMC
HEALTHCARE

LAURENCE M. MERLIS
President & CEO

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April 25, 2007

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

Re: A Revision of the Uncompensated Care Methodology

Dear Bob:

On behalf of the Greater Baltimore Medical Center (GBMC), we support the Staff proposal of April 11, 2007, "A Revision of the Uncompensated Care Methodology."

We believe the proposed methodology achieves the HSCRC primary objective of incorporating outpatient uncompensated care into the regression result while continuing to maintain the improvements to the uncompensated care (UCC) methodology that were introduced in rate year 2007

GBMC and MedStar worked collaboratively in helping to define an alternative to the current UCC methodology, and participated in the MHA Financial Technical Issues Task Force process that evaluated numerous alternatives and criteria during the past year for the purpose of selecting an improved uncompensated care methodology.

The current proposal, forwarded to the HSCRC Staff by the MHA Financial Technical Issues Task Force and Council on Financial Policy, is a significant improvement over the current methodology based on the following:

1. Demonstrates improved statistical results (i.e. R-squared values for the regression equation).

2. Provides relative stability when measured over a three-year time period.

3. Utilizes a consistent measure of gross revenue within the numerator and denominator for all the independent regression variables.

In addition, the current proposal also maintains the major improvements made to the UCC methodology in rate year 2007, including:

1. Each hospital's UCC rate is based upon a 50/50 blend of the most recent three-year actual average for uncompensated care and a regression-based predicted value (where the regression coefficients are also determined using the most recent three years of data).

2. The statewide percentage placed into rates for the upcoming rate year is adjusted to match the statewide percentage funded in the most recently completed rate year (i.e. the statewide UCC percentage placed into rates for rate year 2008 will match the statewide percentage that was funded in rate year 2006).

Dr. Cohen, at the April HSCRC meeting, correctly noted that although the statewide percentage placed into rates for the upcoming rate year reflects that of the prior rate year, that actual UCC dollars funded will continue to grow in rate year 2008 due to HSCRC approved rate increases. It is important to recognize the fact that while the amount of uncompensated care dollars funded statewide may continue to grow, this result is in no way related to the current staff proposal. The proposed methodology maintains the current UCC policy criteria of requiring the statewide percentage funding to match the previous rate year.

For the reasons outlined above, we hope the Commission will approve the Staff recommendation. Thank you for the opportunity to comment on this issue. At your request, we are available to address any questions the Commissioners and Staff may have regarding our comments.

Respectfully,

Laurence Merlis
President & CEO

Michael J. Curran
Executive Vice President
and Chief Financial Officer

MedStar Health

April 25, 2007

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

Re: A Revision of the Uncompensated Care Methodology

Dear Bob:

On behalf of MedStar Health, I would like to show our support for the Staff proposal of April 11, 2007, "A Revision of the Uncompensated Care Methodology".

We believe the proposed methodology achieves the HSCRC's primary objective of incorporating outpatient uncompensated care into the regression result while continuing to maintain the improvements to the uncompensated care ("UCC") methodology that were introduced in rate year 2007.

MedStar Health and other healthcare organizations worked collaboratively in helping to define an alternative to the current UCC methodology. We also participated in the MHA Financial Technical Issues Task Force process that evaluated numerous alternatives and criteria during the past year for the purpose of selecting an improved uncompensated care methodology. This final proposal was then endorsed by MHA's Council on Financial Policy.

We believe that this proposal, which was forwarded to the HSCRC Staff by the MHA Financial Technical Issues Task Force and Council on Financial Policy, is an improvement over the current methodology based on the following:

- it maintains the current UCC policy criteria of requiring the statewide percentage funding to match the previous rate year
- it utilizes a consistent measure of gross revenue within the numerator and denominator for all the independent regression variables
- it produces stability when measured over a three-year time period
- it demonstrates improved statistical results.

5565 Sterrett Place – 5th Floor, Columbia, Maryland 21044
phone: 410 772 6630 • *fax:* 410 740 1106 • *e mail:* michael.j.curran@medstar.net

We thank the HSCRC staff for working with us and the hospital industry to further improve the UCC methodology. We appreciate the time spent reviewing the proposals and preparing the staff recommendation. We value your support and are pleased to offer our comments on this improved UCC methodology.

For the reasons outlined above, I hope the Commission will approve the Staff recommendation. I will be available at your request to address any questions the staff and commissioners have regarding our comments.

Respectfully,

Michael Curran

April 26, 2007

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

Dear Mr. Murray:

This letter is intended to indicate the support of Washington County Hospital Association for the proposed revision to the Uncompensated Care Methodology presented at the April 11, 2007 HSCRC meeting. The proposed methodology, with the inclusion of outpatient statistics, is a superior model to the current methodology and results in a more accurate prediction of actual uncompensated care costs. As indicated in the staff paper, the proposed model has a significantly higher R-square than the current model and more accurately allocates UCC allowances throughout the state of Maryland.

The key points of this proposal are outlined below:

- The current proposal incorporates the primary component of the original Washington County proposal – i.e. an outpatient variable to the regression equation for measuring uncompensated care.

- The most significant changes made by the current proposal to the initial Washington County proposal is to:

    1. Have a common measurement statistic (gross revenue) throughout the numerator and denominator of the independent regression variables which is to simplify the regression and eliminate the potential for unintended consequences by using EIPD's.

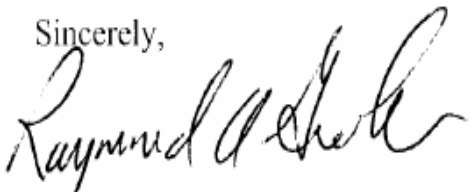
    2. Add a second outpatient regression variable that attempts to pick-up outpatient uncompensated care not occurring in the emergency department.

- Washington County revised its original proposal at the very end of the MHA Financial Technical Issues Task Force process that was evaluating the UCC

methodology – Washington County's revised proposal was nearly identical in the results it produced, as well as the measurement statistic (i.e. gross revenue) to the current proposal.

Washington County Hospital strongly supports the implementation of the proposed methodology in SFY 2008. Thank you for your consideration.

Sincerely,



Raymond A. Grahe
Vice President for Financial Services

C: J.P. Hamill
P. Sokolowski, MHA

ATLANTIC
GENERAL HOSPITAL

April 26, 2007

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

Dear Mr. Murray:

This letter is intended to indicate the support of Atlantic General Hospital for the proposed revision to the Uncompensated Care Methodology presented at the April 11, 2007 HSCRC meeting.

The proposed methodology, with the inclusion of outpatient statistics, is a superior model to the current methodology and results in a more accurate prediction of actual uncompensated care costs. As indicated in the staff paper, the proposed model has a significantly higher R-square than the current model and more accurately allocates UCC allowances throughout the state of Maryland.

Atlantic General Hospital strongly supports the implementation of the proposed methodology in SFY 2008. Thank you for your consideration.

Sincerely,

Cheryl L. Nottingham, CPA, MBA
Vice President, Finance

CLN:idc

Civista Medical Center
701 East Charles Street
P.O. Box 1070
La Plata, Maryland 20646-1070

301.609.4000 Phone

April 26, 2007

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

Dear Mr. Murray:

This letter is intended to indicate the support of Civista Medical Center for the proposed revision to the Uncompensated Care Methodology presented at the April 11, 2007 HSCRC meeting. The proposed methodology, with the inclusion of outpatient statistics, is a superior model to the current methodology and results in a more accurate prediction of actual uncompensated care costs. As indicated in the staff paper, the proposed model has a significantly higher R-square than the current model and more accurately allocates UCC allowances throughout the state of Maryland.

CIVISTA Health

Civista Medical Center strongly supports the implementation of the proposed methodology in SFY 2008. Thank you for your consideration.

Sincerely,

Mickey Slade
VP Finance, CFO

MS:kbw

Maryland
Hospital Association

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

April 26, 2007

Sent via fax. Hard copy to follow.

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

RE: APRIL 11, 2007 DRAFT UNCOMPENSATED CARE POLICY RECOMMENDATION

Dear Bob:

The purpose of this letter is to comment on the April 11, 2007 staff recommendation on the Uncompensated Care Policy.

MHA's Financial Technical Issues Task Force and Council on Financial Policy endorse the changes to the methodology that include outpatient variables in the regression. The introduction of these variables strengthens the explanatory power of the regression. As you know, both the staff and the industry have been concerned that the existing regression had deteriorated over the years.

Currently, the HSCRC and MHA are attempting to reconcile some difference with the data and the results of the regression. We believe that these differences to be minor in nature and not reflective of any flaw in the overriding policy.

We appreciate the commission staff's patience and willingness to actively participate in developing a recommendation that hospitals and commission staff believe enhance the rate setting methodology. Taking the time to thoroughly review each possible option, and to consider the resulting technical issues and the policy implications, has led to a recommendation that hospitals and commission staff believe enhances the rate setting methodology.

Sincerely,

Traci

Traci Phillips
Director, Health Care Finance

cc: John O'Brien

bj/X:\Finance Team Shared_NEW\Comment Letters\MHA Letters to HSCRC\2007 Letters\2007.04.26.Murray.T21.MHA.TP.a.doc

Adventist HealthCare

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www.AdventistHealthCare.com

April 25, 2007

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

Dear Bob,

This letter is intended to indicate the support of Adventist HealthCare's two hospitals – Shady Grove Adventist Hospital & Washington Adventist Hospital - for the proposed revision to the Uncompensated Care Methodology presented at the April 11, 2007 HSCRC meeting.

We believe the proposed methodology, with the inclusion of outpatient statistics, is a better model to the current methodology and results in a more accurate prediction of actual uncompensated care costs. As indicated in the staff paper, the proposed model has a significantly higher R-square than the current model and more accurately allocates UCC allowances throughout the state of Maryland.

Based on the above facts, Adventist HealthCare strongly supports the implementation of the proposed methodology in SFY 2008.

Thank you for your consideration.

Sincerely,

James G. Lee, FACHE, FHFMA
Senior Vice President
Chief Financial Officer

Xc: Ron Benfield, VP/CFO, Shady Grove Adventist Hospital
Paul Nicholson, VP/CFO, Washington Adventist Hospital