Attachment IV

MEMORANDUM

To: Prince George's Hospital System Improvement Task Force

From: Sylvia Quinton and Robert G. Brewer, Jr.

Re: Dimensions HealthCare System's Relationship with its Bond Trustees and Prince George's County

Date: November 6, 2002

The Prince George's Hospital System Improvement Task Force is developing recommendations for enhancing the long-term stability of the hospital system. To assist the Task Force in its deliberations, this Memorandum provides some analysis of the various legal issues involved with a possible closure of hospital facilities by Dimensions HealthCare System ("Dimensions") or the possible default by Dimensions in its bond indebtedness. The Task Force did not request this analysis with the expectation that these events would necessarily occur, rather the Task Force needed this background information to make decisions about Dimensions' long-term options.

I. Bond Indebtedness

Dimensions currently is the borrower on approximately $80 million of tax-exempt revenue bond indebtedness. This indebtedness is not guaranteed by Prince George's County (the "County"), and is not secured by a mortgage on the various premises owned or leased by Dimensions. However, Dimensions has assigned to the Bond Trustee its interest in premises leased from the County pursuant to the County Lease, with the County's consent. Dimensions' revenues are pledged to the Bond Trustee to pay the outstanding indebtedness.

If Dimensions defaults on its bond indebtedness (which can arise in a number of circumstances, including missing principal and/or interest payments, failing to maintain cash flow ratios, failing to maintain adequate reserves, etc.), then the Bond Trustee can pursue its remedies. After notice and cure periods, the Bond Trustee can declare the entire indebtedness due and payable, and, among other remedies, take possession of the leased premises under the Lease. This right of the Bond Trustee must be exercised within six months of its acceleration of the indebtedness.

The Bond Trustee also has various other contractual remedies which it can pursue to collect the accelerated indebtedness. These are rather typical rights vested in any lender, and are not unique to Dimensions.

II. Prince George's County Relationships

Prince Georges County leases the land and buildings on the Prince George's Hospital Center, Laurel Regional Hospital and Bowie Health Center campuses to Dimensions under a long term lease. In addition, Dimensions contracts with the County to provide various health care services on a "fee for service" basis. The County has various remedies available to it for any default by Dimensions under the Lease and under service contracts. The County has a security interest in all of the real and personal property on the premises covered by the Lease; the Lease does not cover all of the facilities comprising the Dimensions system. Subject to the rights of the Bond Trustee, the County controls further encumbrances (such as mortgages) on the leased premises, and must consent to any proposed assignment of the Lease from Dimensions to a third party (subleasing does not require the County's consent).

The Lease contains many obligations to be fulfilled by Dimensions to the County, including: (a) provide community services, which can be modified or discontinued, subject to the veto of Board representatives appointed by the Prince George's County Executive and the Prince George's County Council; (b) provide employees with competitive employee benefits and bargain in good faith with labor unions; (c) cooperate with the County in its exercise of its oversight rights relating to quality of patient care, indigent care and community services, and financial reports; (d) repair and maintain facilities, and replace all equipment, as necessary, for proper hospital operations; (e) provide and care for all patients residing or employed in the service areas of the hospitals diagnosed as seriously ill or requiring emergency services without regard for the ability of such patients to pay for services rendered; (f) obtain the consent of the County to any purchase or management of other facilities, subject to certain qualifications; (g) maintain its corporate Bylaws to provide for a number of designated Board slots for representatives of various constituencies.

If Dimensions defaults in its performance of any of the foregoing obligations, the County can exercise its default rights under the Lease, subject to the rights of the Bond Trustee and notice and cure rights described in the Lease. Ultimately, the County may terminate the Lease and reacquire ownership of the leased premises, equipment, etc. from Dimensions. If that occurs, the County would have possession of the health care facilities now leased by Dimensions (Prince George's Hospital Center, Laurel Regional Hospital, and Bowie Health Center). While the County would have no obligation to operate these facilities if they were properly closed under Maryland Health Care Commission guidelines, their closure would leave a significant shortage of healthcare resources available for the citizens of the County, and exacerbate current problems regarding access to care and out-migration to neighboring counties and the District of Columbia for hospital services.

In addition to the Bond Trustee, bond holders and the County and their rights arising under the bond documents and the Lease, there are numerous other parties who would be affected by any general inability of Dimensions to meet its service and financial obligations. These affected parties include the County (under various service contracts being performed by Dimensions for patient groups), employees (including employed physicians), independent contractors who render services to Dimensions, vendors and suppliers of goods and services, insurers and payors (for contractual adjustments), and miscellaneous unsecured and perhaps secured creditors. Dimensions would be exposed to numerous breach of contract cases seeking damages for non-performance. In general, Dimensions would not be subject to injunctive relief for continued performance of contracts it if lacked the financial ability to perform them.

III. Bankruptcy

It is always possible that Dimensions could file bankruptcy to avoid incurring the enforcement remedies of the County or the Bond Trustee. Such bankruptcy proceedings could be either to reorganize its finances or to liquidate its assets. The bankruptcy court generally has very broad power to reform, reject or assume contracts Dimensions has with others. It is very difficult to predict the outcome of a possible bankruptcy scenario, other than to observe that it is an option occasionally used in the health care industry to restructure debt and other onerous obligations.

IV. Duties to Patients

Dimensions has various statutory obligations to continue to treat patients in its facilities despite any financial difficulties. While bankruptcy proceedings may affect these obligations, Dimensions still must make suitable arrangements for the appropriate care of patients under active treatment. No creditor, including the County or the Bond Trustee, has the obligation, by contract or by law, to fulfill these obligations of Dimensions. To our knowledge, the County has no legal obligations arising out of the Lease or otherwise to care for the health care needs of its residents other than those it undertakes voluntarily, which it then must do in accordance with applicable standards of medical care. However, the County may have a fiduciary duty to assure adequate health care for its most vulnerable citizens due to its historical active involvement with Dimensions and its predecessor entities and its continued ownership of significant health care assets.

Regulatory Matters Upon Hospital Closure; Bond Program

If Dimensions or the Bond Trustee elected to close one or both of the acute care hospitals (and perhaps the emergency room at Bowie Health Center), the Maryland Health Care Commission has a process related to its certificate of need laws requiring public notice and Commission comment before closure can occur. Federal law requires a sixty day notice if the termination of employment of a large number of employees is contemplated. The State of Maryland also has a Hospital Bond Program designed to

assure the repayment of tax-exempt bonds for hospital facilities and the extraordinary costs of closure, net of the proceeds from asset sales and transfers of facilities to affiliated entities.

Under Maryland law, when a hospital is to be closed or converted to another use, it is possible for the public body obligations of the hospital as well as the costs of closure to be paid through an assessment on each hospital whose rates are approved by the HSCRC. Summarized below is the process and circumstances under which those payments are made under the Hospital Bond Program (the "Program").

Statutory Procedures. There are three different statutory avenues by which a hospital may close:

> (1) the hospital may file a notice of intent to close with the Health Care Commission ("HCC");
>
> (2) the hospital may seek approval by the HCC to convert to another type of facility; or
>
> (3) the HSCRC together with the HCC may petition the Secretary of the Department of Health and Mental Hygiene to delicense the hospital.

Any of these procedures may invoke the Program to pay public bond obligations and costs of closure. Depending upon the procedure followed and the number of hospitals in the county in which the hospital proposed to be closed/converted is located, there are different notices to be given such that the HCC, the HSCRC and MHHEFA are all aware of the proposed closure/conversion. Of those different public bodies, there must be certain findings, e.g., whether the closure is in the public interest and not inconsistent with the State Health Plan that has been put in effect by the HCC. Those public bodies must in turn give notice to MHHEFA no later than 150 days prior to the proposed closure that the public body has discharged its obligations and the hospital will close. MHHEFA then administers the Program in the context of the closure of this hospital.

Outstanding Public Body Obligations. The hospital proposed for closure/conversion must supply the HSCRC and MHHEFA with a list of outstanding public body obligations.[1] Within 60 days, MHHEFA must prepare a schedule of

[1] A "public body obligation" is any bond, note or evidence of indebtedness issued by MHHEFA, the State of Maryland, any agency, instrumentality, or public corporation of the State, any public body defined in Maryland statutes, the Mayor and City Council of Baltimore, or any municipal corporation subject to certain provisions of the Maryland Constitution. A "public body obligation" does not include any obligation if (1) the obligation is insured by an effective municipal bond insurance policy and issued on behalf of a hospital that voluntarily closes under the first process outlined above (2) the proceeds of the obligation were used in connection with a facility that primarily provides outpatient services, or (3) the proceeds of the obligation were used to finance a facility primarily used by physicians who are not employees of the hospital for the purpose of providing services to nonhospital patients.

payments necessary to meet the public body obligations of the hospital. MHHEFA is to consult with the HSCRC and the issuer of the public body obligations and then develop a plan to finance, refinance or otherwise provide for payment of the public body obligations. The proposed plan may include any tender, redemption, advance refunding or other technique deemed appropriate by MHHEFA.

Closure Costs.[2] The HSCRC may determine to provide for payment of any or all of the costs of closure of a hospital having outstanding public body obligations. In order to provide for payment, the HSCRC must find that payment of the closing costs is necessary or appropriate to encourage and assist the hospital to close or convert or otherwise implement the Program. In making its determination, the HSCRC is to consider the amount of the system-wide savings to the State health care system and the recommendations of the HCC. The HSCRC is to act within 60 days of receiving the notice of closure or conversion by giving notice of its decision of whether to provide payment and what portion, if any. The statute specifically provides that the HSCRC is not required to provide for payment of any closure costs. As soon as practicable, MHHEFA is to prepare a proposed plan to finance, refinance or otherwise provide for the payment of the closure costs as determined to be paid by the HSCRC.

Upon direction from the HSCRC, MHEFFA may begin to prepare plans with respect to either the public body obligations or closure costs before a final determination is made upon the closure or conversion.

MHHEFA Action. MHHEFA is authorized to issue negotiable bonds or notes to implement its plan to provide payment of the closure costs or public body obligations. In connection with the issuance of any bond or note, MHHEFA is given authority to assign its rights under any loan, lease or other financing agreement between MHHEFA or any other issuer of a public body obligation and the closed or converted hospital in consideration for the payment of a public body obligation.

Assessment of Fees. In order to provide the money to pay the closure costs and the public body obligations as determined through the process above, the HSCRC assesses a fee on all Maryland hospitals whose rates are approved by the HSCRC. The amount of the fee must be sufficient to: (1) pay the principal and interest on the existing public body obligations or the bonds or notes issued by MHHEFA, (2) pay the closure costs or the principal and interest on any bonds or notes issued by MHHEFA to finance the closure costs; (3) maintain any reserve required in connection with the public body obligation; (4) pay any required financing charges; and (5) maintain any reserves deemed appropriate by MHHEFA.

[2] "Closure costs" are the reasonable costs determined by the Health Services Cost Review Commission, including expenses of operating the hospital, payments to employees, employee benefits, fees of consultants, insurance, security services, utilities, legal fees, capital costs, costs of terminating contracts with vendors, suppliers of goods and services and others, debt service, contingencies and other necessary or appropriate costs and expenses.

Calculation of Fees. The relative fee assessed each hospital is determined by the ratio of the actual gross patient revenues of the hospital to the total gross patient revenues of all hospitals determined as of the date deemed appropriate by MHHEFA after consultation with the HSCRC. The fees are paid directly by each hospital to MHHEFA or as otherwise directed by MHHEFA.

Reduction in Qualified Public Bond Obligations. The statute provides that the public bond obligation that might otherwise qualify for payment as provided above is to be reduced by (1) the amount by which the value of any assets transferred to any affiliates exceeds the value of any assets received from the affiliates (2) the total value of all property to be retained by the hospital or any affiliate, and, of course (3) any proceeds realized by the sale of hospital assets. MHHEFA will make this determination based upon appraisals.

Authorization to Proceed to Collect Money. MHHEFA is authorized to proceed to collect on any guaranty of the public obligation bonds if such action is necessary to protect the interest of the bondholder or consistent with the public purpose of the Hospital Bond Program. In determining whether to proceed, MHHEFA is required to consider the circumstances under which the guaranty or other collateral was provided and the recommendations of the HSCRC and the HCC. Any amount collected shall be offset against the amount assessed by the HSCRC against all Maryland hospitals.

Purpose. The statute explicitly states that the purpose of the statute is to bring the HCC, HSCRC and MHHEFA together and take into account each other's recommendations with respect to the closure/conversion of hospitals.

Conclusiveness of MHHEFA Determinations. The statute provides that the determinations of MHHEFA involving the validity or enforceability of any bond or note or any security for a bond or note shall be conclusive and binding.

In summary, whenever a hospital is closed by following the prescribed statutory process, then the Maryland Hospital Bond Program is available to repay the existing bonds and closure costs if certain conditions are met. The funds for repayment are generated by a fee assessed on all hospitals whose rates have been approved by the Health Services Cost Review Commission ("HSCRC"). §19-223 of the Health-General Article. There is no direction provided in the statute as to how the amount of the fee is to be determined, including the length of time over which the fee should be calculated in order to repay the costs or the size of the fee relative to all hospitals. This appears to be a matter of discretion for the HSCRC. The Maryland Hospital Bond Program is operated within the Maryland Health and Higher Educational Facilities Authority (MHHEFA).

V. Acquisition and Conversion of Nonprofit Hospitals

The acquisition and conversion of nonprofit hospitals are governed by the provisions of State Government Article, Title 6.5, Annotated Code of Maryland. On September 20, 2002, in the Maryland Register (Vol. 29, Issue 19), the Office of the

Attorney General published proposed new Regulations .01 - . 07 under a new chapter, COMAR .02.05.01 Applications for Hearings on the Acquisition and Conversion of Nonprofit Hospitals. The purpose of the action is to establish regulations regarding the conversion and acquisition of nonprofit hospitals. Currently, there are no regulations regarding this matter. Also, there is no corresponding federal standard to the proposed regulations. The proposed regulations specifically articulate numbers and materials to be included in an application, financial and community impact report, and other expert assistance required for conversion or acquisition of a nonprofit hospital. The scope of public access to documents, the process for requesting access to documents, the public hearing, and required decisions are provided as well.

The Attorney General, in consultation with the Department of Health and Mental Hygiene, is the regulating entity to provide the approval for a conversion or acquisition of a nonprofit hospital. The application for conversion or acquisition must be submitted to the Attorney General. The application must include: (1) the name of the transferor, (2) the name of the transferee; (3) the names of any other parties to the acquisition agreement, (4) the terms of the proposed acquisition, including sale price; (5) a copy of the acquisition agreement; (6) a financial and community impact analysis report from an independent expert or consultant; and (7) other documents related to the acquisition. Within 10 working days after receiving an application, the Attorney General must publish the notice in the most widely circulated newspapers that are part of the nonprofit hospitals service area and notify any person that has requested in writing to be notified of the filing of an application. The notice must: (1) state that an application has been received, (2) state the names of the parties to the acquisition, (3) describe the contents of the application, (4) state the date by which a person must submit written comments on the application, and (5) provide the date, time, and place of the public hearing on the acquisition. The Attorney General must hold a public hearing no later than 90 days after receiving a complete application, including all necessary expert reports. The public hearing must be held in the jurisdiction where the hospital is located.

The Attorney General must approve the acquisition, with or without modifications or disapprove the acquisition within 60 days after the record has been closed. The Attorney General may extend for good cause a 60-day period of time for making a determination. The Attorney General is limited to a maximum of two 60-day extensions for making a determination on the same application. The determination takes effect 90 days after the date of the determination.

The Attorney General may not approve an acquisition unless it finds the acquisition is in the public interest. The statute provides steps to ensure that the acquisition is in the public interest.

A portion of the hospital assets, forty percent (40%), will be distributed to the Maryland Health Care Foundation. The remaining sixty percent (60%) will be distributed to a public or charitable entity or trust that is dedicated to the health care needs of affected community and independent of the transferee.

On request to the Attorney General, the application and related documents must be made available for public inspection and copying. The Maryland Public Information Act, State Government Article, Title 10, Subtitle 6, Annotated Code of Maryland applies to public access to the application and documents generated upon review of an application. However, all information and documents filed are confidential, not subject to subpoena, and not to be made public by the Attorney General or any other party. The material may be made public by prior written consent from the person to whom the material relates. The Attorney General may disclose all or part of material otherwise confidential if the Attorney General determines that disclosure is in the interest of the policyholders, stockholders, or the public. The Attorney General must give the applicant notice and an opportunity to be heard before disclosing any material. The regulations (effective December 12, 2002) provide that if the Attorney General grants a request for inspection or copying, the material shall be produced within a reasonable period not to exceed 30 days from the date of the receipt for the request.

F. Conversion From Nonprofit to For-Profit Status

A nonprofit hospital fulfills a special mission in the health service industry. They are created to meet the health needs of a particular community and to fulfill broad public purposes. This creates a fiduciary obligation of the hospital to the public and to the people they serve. Nonprofit hospitals have been rewarded for their public commitment by special tax treatment and recognition such as government subsidies.

A conversion is the transfer of assets from a nonprofit to a for-profit and sometimes other nonprofit health care organizations through sales, mergers, joint ventures, or corporate restructuring. A conversion provides an opportunity to gain access to capital, enhance competitive positions, secure maximum assets, or remain viable and stay competitive. The converted assets must be used in a manner consistent with the original nonprofit's mission. The Attorney General applies the common law *cy pres* doctrine, meaning "as close as possible. The doctrine supports an application of the assets to a mission as close as possible to that of the original nonprofit. Some conversion transactions have led to the creation of new foundations endowed with the assets generated by the conversion that are charged with funding health-related activities in their communities.

There are two public policy issues at stake in conversions:

(1) Health Services – indigent care, emergency room coverage, and other hospital services that are critical for maintaining healthy communities; and

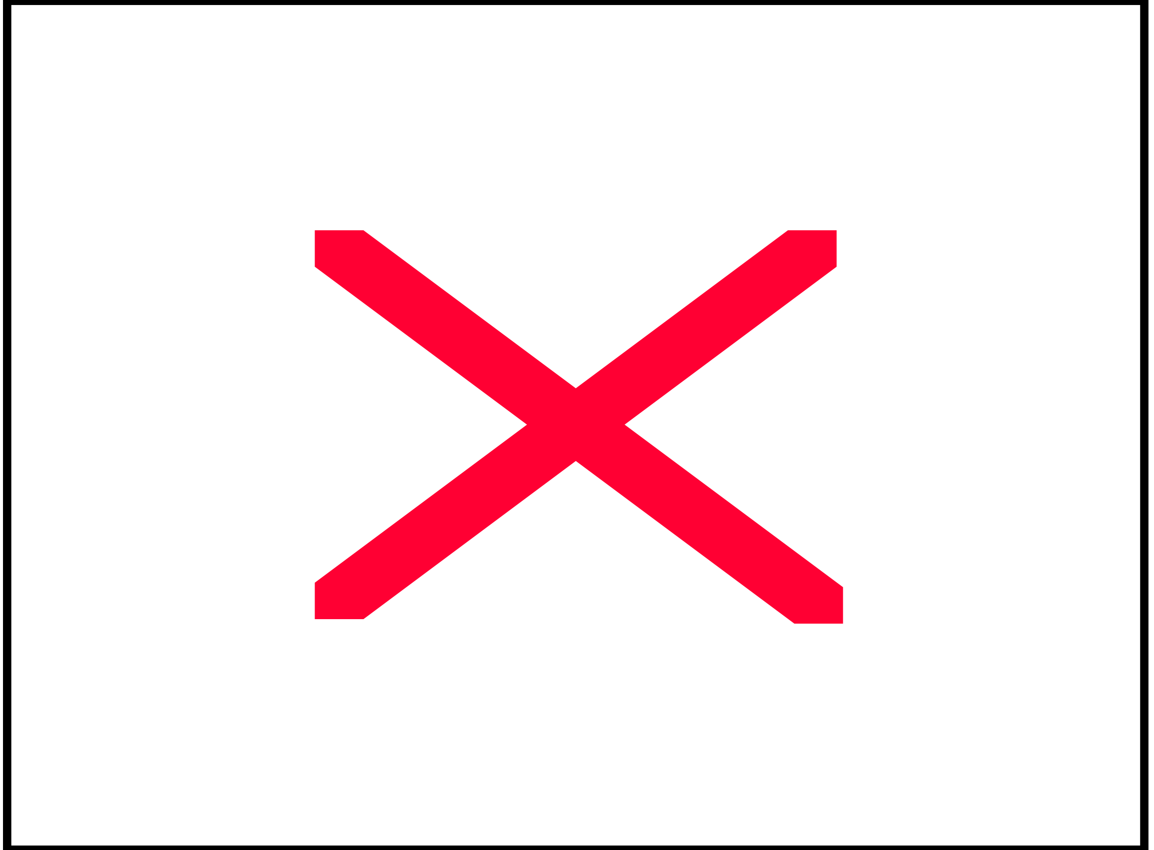
(2) Nonprofit Assets - maintaining the level of public benefit presumed to have been provided by the nonprofit organization prior to the conversion.

Access to crucial health services is an extremely important issue during a conversion. There are questions regarding the prioritization, continuation or expansion,

reduction or elimination of health services; subsequent sales, mergers, or transfers to new owners; insolvency or closure of the for-profit; and quality, accessibility and affordability of health care in the affected community.

The protection of public assets requires a keen review of a transaction between a nonprofit and the for-profit. It is important to know the true value of the assets, as well as to ensure a preservation of the assets for nonprofit purposes and independence from the converting corporation.

Attachment V
Map of Other Hospitals in the Dimensions Health System Region



Attachment VI
Department of Health and Mental Hygiene
Report on the Maryland Medical Assistance Program and Maryland Children's Health Program – Reimbursement Rates Fairness Act
September 2002

I. Introduction

Chapter 464 (Senate Bill 481) of the 2002 Session directs the Department of Health and Mental Hygiene to establish a process to annually set the fee-for-service reimbursement rates for the Maryland Medical Assistance Program and the Maryland Children's Health Program in a manner that ensures participation of providers. The legislation further stipulates that in developing the rate setting process, the Department shall take into account community rates as well as annual medical inflation, or utilize the current Resource Based Relative Value Scale (RBRVS) system used in the federal Medicare program or the American Dental Association Current Dental Terminology (CDT-3) Codes. The legislation also directs that by September 1 of each year, the Department should submit a report to the Governor and various House and Senate committees on the following:

1. Progress in establishing the rate setting process mentioned above;
2. Comparison of Maryland's Medicaid reimbursement rates with that of other states;
3. The schedule for bringing Maryland's reimbursement rates to a level that assures provider participation in the Medicaid program; and
4. Estimated costs of implementing the schedule in item 3 and proposed changes to the fee-for-service reimbursement rates.

In September 2001, the Department prepared a report in response to Chapter 702 (House Bill 1071) of the 2001 Session analyzing the reimbursement rates being paid by the Maryland Medicaid and Children's Health Programs. The report included comparisons of Maryland's Medicaid fee schedule with the Medicare program's average payments in Maryland, as well as with Medicaid fee schedules in other states. The Department's analysis showed that Maryland's Medicaid reimbursement rates in 2001 were, on average, about 36 percent of 2001 Medicare rates. The report also included the results of a survey conducted by the American Academy of Pediatrics in 1998/1999 that showed, for a subset of procedures, Maryland ranked 47th in the country in physician reimbursement.

Based on the results of the 2001 report, the Governor and the legislature appropriated an additional $50 million (total funds) for physician fees in the Medicaid program for the fiscal year beginning July 2002. The additional funding raised overall average Medicaid reimbursement rates in Maryland to 62 percent of 2002 Medicare rates. The increase was targeted to a specific set of procedure codes used largely by primary care and office-based specialty care providers. Reimbursement rates for the codes that were targeted by

the additional funding increased from an average of 33 percent to an average of 80 percent of 2002 Medicare fees.

It is important to remember that comparisons to the Medicare fee schedule are fluid. Medicare rates are adjusted annually according to a complex formula designed to control overall spending, while accounting for factors that affect the cost of providing care. In some years, including 2002, overall Medicare rates have actually decreased.

The remainder of this report is organized in four sections. Section Two provides background information on Medicaid reimbursement issues. Section Three reviews the progress of the Department in adjusting fee-for-service rates for physicians and oral health services. Section Four assesses Maryland's reimbursement rates based on how they compare to Medicare payments and other states' payment rates. Section Five provides recommendations on an annual process to review reimbursement rates and the estimated cost of an additional increase in physician fees.

II. Background

Concerns about the level of provider reimbursement under Maryland's Medicaid fee-for-service program have been expressed in a variety of forums. This issue affects the Medicaid HealthChoice program as well because most MCOs' payment rates to physicians are built upon the Medicaid fee-for-service fee schedule. The Medicaid Advisory Committee has raised concerns about the impact of provider reimbursement on access to care. Low reimbursement rates were cited as the leading issue during the provider forums for both dentists and physicians conducted as part of the recent HealthChoice evaluation. Some Medicaid providers have threatened to leave the program or have already left, largely because of low reimbursement rates. Prior to the fee increase in July 2002, Medicaid physician fees had not been increased in over ten years. In July 2000, the Medicaid program on average tripled the fee schedule for dentists. However, reimbursement for dentists under the Medicaid program is still below commercial rates.

In recent years, the Maryland Medicaid program has undergone significant expansion putting additional stress on the existing provider networks. Medicaid enrollment of children has grown by over 150,000 since 1998, due primarily to the implementation of the Maryland Children's Health Program (MCHP). The demographics of this newly eligible population increase the need for primary care providers, especially pediatricians and family practitioners, for well-child visits and Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services. There is also an increased demand for dental services. The HealthChoice evaluation showed that in both Western Maryland and the Eastern Shore, just under 30 percent of the population under age 20 was enrolled in HealthChoice as of 2000, more than double the level of 1990. Twenty-two percent of children were in the Medicaid program statewide. These numbers have continued to increase over the past two years. As the total Medicaid population has increased, the number of Medicaid patients within each provider's practice has increased. In turn, the

level of Medicaid revenues becomes increasingly important to the viability of each practice.

As noted above, prior to July 2002, physician fees had not increased in Maryland for over a decade, while fees for most other Medicaid covered services have increased. The majority of Medicaid dollars are spent on components of health care (hospital inpatient and outpatient, nursing home, pharmacy, etc.) whose reimbursement rates regularly increase. For example, the Health Services Cost Review Commission (HSCRC) considers inflation in its annual review of hospital rates. Nursing home rates are also automatically adjusted annually in accordance with State law to reflect increasing costs. The greatest component of prescription drug costs, ingredient fees, has increased as the cost of inputs rises. Fees for other providers, including Federally Qualified Health Centers, Home Health Agencies and Medical Day Care Providers are also adjusted annually.

During the 2000 and 2001 Sessions, the General Assembly considered a range of options for addressing Medicaid reimbursement rates in an effort to ensure provider participation in the program. The resulting legislation, Chapter 702 (House Bill 1071) of the 2001 Session, directed the Department of Health and Mental Hygiene to establish a process to annually set the fee-for-service reimbursement rates in a manner that ensures participation of providers. The Department's 2001 report documented that Maryland Medicaid reimbursement rates were, on average, about 36 percent of 2001 Medicare rates and that Maryland ranked 47th in physician reimbursement according to an American Academy of Pediatrics study of 1998/1999 rates. As a result of its analysis, the Department recommended an annual comparison of the Medicaid fee schedule to Medicare rates and an additional $50 million targeted to certain procedure codes to increase overall physician reimbursement.

III. Progress on Adjusting Rates

A. Reimbursement for Physicians' Services

One of the most significant challenges in addressing reimbursement increases is targeting any new resources to assure they will have a meaningful impact, while still addressing the most significant issues affecting all populations. Visits to physicians who provide primary care to women and children, such as pediatricians, general practitioners, and obstetricians/gynecologists, account for the majority of services under the Medicaid program.

The Department targeted the July 2002 increase in reimbursement rates to Evaluation and Management procedures. These procedures are usually office visits provided by either a primary care provider or a specialist. Primary care providers, such as pediatricians and general practitioners, bill high proportions of Evaluation and Management services. Specialists, including hospital-based physicians, also provide Evaluation and Management services and therefore also benefit from the higher reimbursement rates.

The Department used the Medicare physician payment methodology to allocate the new fees and to determine the new physician fee schedule. Medicare fees are based on the Resource Based Relative Value Scale (RBRVS) which relates payments to three types of expense incurred by physicians to deliver patient services: physician work, practice expense, and malpractice expense. Effective July 2002, Maryland Medicaid reimburses physicians for the full practice and malpractice expense components for Evaluation and Management procedures, and covers, within State resources, a portion of the work component.

With this adjustment in fees, the Department increased the reimbursement rates for Evaluation and Management procedures (CPT codes 99201 through 99499) from an average of 33 percent to an average of 80 percent of 2002 Medicare fees.

- **Implication of the Fee Increase for Payments to MCOs**

Historically, MCO capitation rates were based on Medicaid fee-for-service expenditures. Current regulations require that MCO capitation rates shall be increased to compensate them for any increase in Medicaid fee-for-service payment rates because this would raise the "base" on which MCO rates are built. The MCO rates were increased on July 1, 2002 to reflect the cost of the physician fee adjustment. To ensure that the MCOs use these funds to raise physician fees to maintain an adequate number of physicians, the Department of Health and Mental Hygiene is using the following method to monitor MCOs' compliance with the fee increase:

- MCOs will be required to pay network physicians at least 100 percent of the new Medicaid fee schedule for the approximately 140 Evaluation and Management procedure codes targeted by the increase; or

- If an MCO wants to use the new revenues to increase other physician fees rather than pay the new fee schedule for the targeted services, it must request a waiver from the Department. The Department will review and approve a waiver if an MCO demonstrates that the total dollar value of the difference between the MCO's current fees for the targeted codes and the new fee schedule is passed on to physicians.

To date, all of the MCOs have decided to pay at least 100 percent of the new fee schedule for the Evaluation and Management codes.

B. Reimbursement for Oral Health Services

Historically, the Maryland Medicaid program has had low dental fees. Despite some recent changes, the rates continue to lag behind commercial reimbursement rates. Unlike physician services, no federal public program, such as Medicare, exists which could serve as a benchmark for oral health service rates. However, the American Dental Association publishes a survey reporting the national and regional average charges for about 165 most commonly used dental procedures, offering data for comparisons.

- **Medicaid Fee-For-Service Rates**

The following table shows the progress Maryland has made in improving reimbursement to dentists for some of the more common services. The last column shows the average fee charged by dentists in the South Atlantic Region.[3] It is important to note, however, that the South Atlantic Average is based on the fees charged by dentists for the service performed, which does not equate to the average payment received as reimbursement from insurance companies or private pay patients.

Table 1 - Oral Health Reimbursement Schedule - Selected Procedures

CDT-3	CDT-2	Description	MA Fee before 7/1/00 rate increase	MA Fee after 7/1/00 rate increase	South Atlantic Average Charge
D0120	00120	Periodic oral evaluation	$5	$15	$25
D0220	00220	Intraoral periapical first film	$3	$9	$14
D0272	00272	Bitewings-two films	$3	$15	$23
D0330	00330	Panoramic film	$21	$42	$63
D1110	01110	Prophylaxis-adult	$12	$36	$49
D1120	01120	Prophylaxis-child	$8	$24	$36
D1201	01201	Topical application of fluoride with prophylaxis	$17	$35	$49
D1203	01203	Topical application of fluoride - no prophylaxis	$17	$14	$19
D1351	01351	Sealant-per tooth	$3	$9	$27
D1510	01510	Space maintainer – fixed – unilateral	$42	$84	$172
D1515	01515	Space maintainer – fixed – bilateral	$48	$144	$245
D2110	02110	Amalgam – one surface, primary	$11	$33	$59

[3] South Atlantic Region consists of: Delaware, District of Columbia, Florida, Georgia, Maryland, North Carolina, South Carolina, Virginia, and West Virginia.

D2120	02120	Amalgam – two surfaces, primary	$17	$42	$74
D2140	02140	Amalgam – one surface, permanent	$13	$37	$69
D2150	02150	Amalgam - two surfaces, permanent	$19	$45	$85
D2330	02330	Resin – one surface – anterior	$13	$39	$81
D2331	02331	Resin – two surfaces – anterior	$19	$48	$99
D2332	02332	Resin – three surfaces – anterior	$22	$56	$121
D2385	02385	Resin – one surface, posterior - permanent	$13	$39	$89
D2386	02386	Resin – two surfaces, posterior, permanent	$19	$48	$115
D2930	02930	Prefabricated stainless steel crown - primary	$27	$75	$148
D3220	03220	Therapeutic pulpotomy	$16	$60	$104
D9230	09230	Analgesia	$6	$18	$34

Note: The South Atlantic average charge is based upon data from the 1999 American Dental Association survey.

Despite the fact that Maryland, on average, tripled reimbursement rates for dentists in July 2000, members of the Oral Health Advisory Committee (OHAC) are concerned that the rates are still too low to provide adequate access, especially to restorative services. A subcommittee of the OHAC has identified a subset of procedure codes included in the above table (D1351 through D9230) that are most meaningful for restorative services.

- **Fees in the HealthChoice Program**

MCOs are required to develop and maintain an adequate network of oral health providers who can deliver the full scope of oral health services. MCOs are not required to pay their oral health providers at Medicaid rates, although many use the Medicaid fee schedule as the basis for their own fee schedules. Furthermore, as a result of legislation passed by the General Assembly in 1998, the Department established enrollee dental utilization standards for the MCOs to meet. The target for the first year of a five year plan, CY 00, was that 30 percent of all children would receive at least one dental service, with annual increases to 40 percent in CY 01, 50 percent in CY 02, 60 percent in CY 03, and 70 percent in 2004.

The MCOs have made progress in achieving the utilization targets. Recent data reports using the HEDIS methodology show that the percentage of children in the HealthChoice program age 4-20 with 320 days or more of enrollment who received one or more dental service during the year increased from 19.9 percent in FY 97 to 32.6 percent in CY 01.

Each year, the Department bases the dental rates paid to MCOs in part on the increasing utilization targets established in the legislation. The Department also takes into consideration the fees that MCOs would pay for each service. The pricing model introduced for CY 03 incorporates fees that are notably higher than the dental fees paid in the Medicaid fee-for-service program. With these funds, the MCOs are expected to maintain an adequate network of providers to deliver oral health services to their members at the target utilization levels.

IV. Analysis of Maryland's Medicaid Physician Reimbursement Rates

A. Comparisons with Medicare Fees

As mentioned earlier, Medicare fees are based on the Resource Based Relative Value Scale (RBRVS). This methodology relates payments to the resources and skills that physicians use to provide a service. Three categories of resources determine the Relative Value Unit (RVU) of each procedure: physician work, practice expense, and malpractice expense. A geographic cost index and a conversion factor are used to convert RVUs to fees. Several factors are used to derive annual adjustments of Medicare fees for inflation, including changes in medical costs, Medicare enrollment, and Gross Domestic Product per capita. In addition, Medicare fees are adjusted depending upon where a procedure is performed. Medicare fees for some procedures are lower if they are performed in hospitals or skilled nursing facilities rather than in offices or other places. Furthermore, Medicare fees may increase or decrease in any given year according to the annual adjustment. A more detailed description of Medicare RBRVS system is included in Appendix 1.

There are about 6,600 procedure codes in the Maryland Medicaid claims and MCO encounter data. (In 2001 we reported 4,300 procedure codes. The increase in number of procedures is because of inclusion of MCO encounter data, which contains additional codes not found in fee-for-service data). About 5,800 or 88 percent of procedures match with the Medicare fee schedule. These procedures account for about 83 percent of total payments (including estimated MCO payments). Many procedure codes in Maryland's Medicaid fee schedule do not exist in the Medicare fee schedule. Examples are local codes that are not nationally recognized Current Procedural Terminology (CPT) codes.

The Department compared Maryland's Medicaid payment rates with the Medicare program's 2002 average payments in Maryland. The analysis indicates that Maryland's Medicaid reimbursement rates before the July 2002 fee increase were, on average, about 41 percent of 2002 Medicare rates for procedures that matched.

(Because of a decline in Medicare fees in 2002, this is higher than the 36 percent of 2001 Medicare fees reported last year). After the increase in fees for Evaluation and Management procedures in July 2002, Maryland's Medicaid rates are, on average, about 62 percent of 2002 Medicare rates. However, there is a wide variation in the fees for individual procedures compared to Medicare fees. Fees for some procedures are much lower than Medicare fees and fees for some procedures are close to Medicare fees. As discussed earlier, reimbursement rates for the 140 Evaluation and Management codes targeted by the additional funding increased from an average of 33 percent to an average of 80 percent of 2002 Medicare fees.

B. Comparison with Other States' Reimbursement Rates

VI.

VII. To offer an alternative point of comparison, the Department looked at other state Medicaid programs' payments to providers. This analysis has the advantage that the populations of Medicaid programs in all of the states are similar, that is, they are all comprised of mostly women and children. As such, all Medicaid programs have defined procedures and reimbursement rates for maternity and immunization services. However, this comparison is very labor intensive and while the populations and programs are similar, the states have different approaches to establishing fees. Also, in many states, provider fees are established based on the current availability of funds. With these caveats, this section of the report provides information on specific physician payment rates across several states and the processes used by other states in updating physician fees.

- **American Academy of Pediatrics Survey**

The Department's 2001 report included the results of an American Academy of Pediatrics' 1998/1999 survey of Medicaid reimbursement rates across the country. Maryland's corresponding numbers of claims for the procedures included in the survey were used to derive weighted average payments for each state. Based on the results, Maryland's rank before the July 2002 fee increase was 47, followed by Washington, DC at 48, New Jersey at 49 and New York at 50.

The American Academy of Pediatrics produced a similar survey in 2001. Based on the 2001 survey data and Maryland's new fees for Evaluation and Management procedures, Maryland's rank is 13. Neighboring states' ranks are: Delaware – 6, District of Columbia – 47, Pennsylvania – 46, Virginia – 15, and West Virginia – 11. The American Academy of Pediatrics survey results for high volume Evaluation and Management procedures for the neighboring states are shown in Table 2, along with the corresponding 2002 Medicare fees and 2002 Maryland Medicaid rates for each listed procedure.

Table 2 - Fees for High Volume Evaluation and Management Procedures

CPT	Description	DC[a]	VA[b]	PA[b]	DE[b]	W.		Medi

Code						VA[b]	MD[c]	Care[c]
99201	New Patient, office visit	$25	$29	$25	$38	$35	$29	$35
99202	New Patient, expanded office visit	$30	$45	$20	$59	$55	$51	$64
99203	New Patient, low complexity	$30	$63	$20	$83	$77	$77	$95
99204	New Patient, intermediate complexity	$35	$91	$20	$120	$110	$109	$135
99205	New Patient, high complexity	$59	$114	$30	$149	$136	$139	$171
99211	Established Patient, office visit	$15	$14	$20	$19	$19	$17	$21
99212	Establish. Patient, expanded office visit	$18	$24	$20	$32	$29	$30	$38
99213	Established Patient, low complexity	$18	$34	$20	$44	$39	$42	$52
99214	Establish. Patient, intermed. complexity	$30	$52	$20	$68	$61	$66	$82
99215	Established Patient, high complexity	$41	$77	$20	$101	$87	$97	$120
99242	Office Visit, straightforward decision	$33	$65	$30	$85	$77	$73	$90
99243	Office Visit, low complexity	$43	$83	$30	$109	$97	$97	$119
99244	Office Visit, intermediate complexity	$60	$115	$49	$151	$134	$137	$169
99245	Office Visit, high complexity	$65	$149	$49	$196	$168	$178	$219

[a]American Academy of Pediatrics Survey of Medicaid Reimbursement (1998/1999)
[b]American Academy of Pediatrics Survey of Medicaid Reimbursement (2001)
[c]Fee schedule as of July 2002

Even with the July 2002 investment in reimbursement rates for Evaluation and Management services, a significant number of procedures still have reimbursement rates that are comparatively low. Table 3 (page 9) compares Maryland's current Medicaid rates with 2002 Medicare rates and rates paid by other states for a sample of common procedures. As the data show, Maryland's Medicaid reimbursement rates are very low for some of these procedure codes. For 13 of the 16 procedures listed, Maryland ranks the lowest in reimbursement compared to Medicare and neighboring states.

Table 3 - Fees for High Volume, non-Evaluation and Management Procedures

CPT Code	Description	DC[a]	VA[b]	PA[b]	DE[b]	W. VA[b]	MD[c]	Medi Care[c]
31500	Intubation Endotracheal	$66	$88	$72	$115	$85		$117

	Emergency						$31	
31622	Bronchoscopy	$117	$162	$166	$212	$171	$113	$248
32020	Insertion of Chest Tube	$130	$169	$211	$220	$160	$42	$215
36489	Insertion of Catheter, Vein	$47	$95	$88	$125	$132	$36	$275
36620	Insertion of Catheter, Artery	$36	$45	$58	$58	$40	$21	$54
43239	Upper GI Endoscopy, Biopsy	$123	$174	$212	$228	$187	$234	$370
44950	Appendectomy	$267	$381	$302	$496	$398	$206	$600
62270	Spinal Puncture, Lumbar, Diagnostic	$35	$88	$42	$116	$131	$18	$200
69436	Tympanostomy, General Anesthesia	$81	$108	$99	$141	$107	$83	$155
92551	Pure Tone Hearing Test, Air Only	$8	$9	$8	$17	$14	$4	NA
92567	Tympanometry, Hearing Evaluation	$6	$15	$12	$20	$16	$5	$21
93303	Transthoracic Echocardiography	$117	$163	NA	$214	$163	$38	$215
93307	Echocardiography, Real Time	$113	$152	$158	$199	$150	$34	$196
93320	Doppler Echocardiography	$50	$66	$107	$87	$66	$52	$86
93510	Left Heart Catheterization	$108	$1,219	$188	$1,596	$1,252	$80	$1,635
94010	Spirometry: Breathing Capacity Test	$16	$21	$15	$28	$18	$13	$39

[a]American Academy of Pediatrics Survey of Medicaid Reimbursement (1998/1999)
[b]American Academy of Pediatrics Survey of Medicaid Reimbursement (2001)
[c]Fee schedule as of July 2002

- **Other States' Medicaid Agencies' Processes for Updating Fee Schedules**

As reported in 2001, we conducted a telephone survey of eleven states with low fee rankings according to surveys by the American Academy of Pediatrics and the Lewin Group. Of the eleven states surveyed, eight states based physician fees on the Medicare RBRVS. One additional state does not base fees on the Medicare schedule but uses it as a comparison point when setting physician fees.

Overall, physician fees for the states surveyed ranged between 50 and 75 percent of the Medicare fee schedule. In most of the states surveyed, increases in physician fees depend

upon budget appropriations. For example, there had been no increase in physician fees in California for fifteen years until the year 2000, when the legislature appropriated funds for an increase. However, because of the current budget deficit, California's Governor has proposed reducing reimbursement rates to physicians that treat their Medicaid (Medi-Cal) patients to the lowest rates in the nation. Most of the other states surveyed noted that fee adjustments were highly dependent upon legislative appropriations, not cost or market influences.

Seven of the states surveyed indicated that they use some physician procedure codes that do not have a corresponding match in the Medicare RBRVS. In most of the states, medical consultants set the corresponding physician fees for these procedures. Availability of funds was most often cited as the basis for adjusting fees for these procedures. One state cited cost as a factor and another cited volume. Several states noted disparate increases for specific codes based on provider input.

V. Recommendation

In its 2001 report, the Department recommended the annual comparison of Maryland's Medicaid rates with Medicare rates in Maryland. The Medicare RBRVS system is based on a methodology that is well accepted by government agencies, physicians, and many private health insurers, which often base their reimbursements on RBRVS. A comprehensive set of Maryland's Medicaid procedures (about 5,800 or 88 percent of procedures) matches with CPT codes. Therefore, these procedures have a corresponding Medicare reimbursement rate. In addition, comparison with Medicare rates does not require significant resource commitment. While some procedures that are relevant to the Medicaid program do not match Medicare rates, the match rate is sufficiently high to allow the State to assess the adequacy of its fees over time.

The Medicare fee schedule remains a relevant comparison point for assessing Medicaid reimbursement in Maryland. By comparing Maryland's Medicaid rates with Medicare rates, the Department is able to assess how reimbursement levels stand compared to a nationally recognized, annually indexed benchmark. With such an annual comparison, the Department can help to maintain the progress gained by the fee increase in July 2002, as well as any future rate adjustments. This information will be annually reported to the Governor and the General Assembly in September of each year. At the same time, the Department can review the physician fees to ensure that the provider network can accommodate any proposed expansion of coverage.

The additional funds provided in 2002 were used to significantly enhance reimbursement for Evaluation and Management codes commonly used by both primary care providers and specialists for office visits. However, as demonstrated by this report, Maryland's Medicaid reimbursement rates for non-Evaluation and Management codes remain well below the rates paid by Medicare. To address this gap, one option is to increase reimbursement for the non-Evaluation and Management procedure codes to a rate that is equivalent to 80 percent of the rate in the Medicare fee schedule. However, it is difficult to quantify the cost of this option

for several reasons. First, not all of the Medicaid codes have an exact Medicare equivalent with a corresponding price. Many of the codes without a match are local codes that are used only in Maryland. Raising only those fees with a matching Medicare code could result in significant disparities among payments to certain types of providers. Therefore, the Department would need to conduct a more complete analysis of all codes to quantify the cost of ensuring equity among these fees.

The implementation of HIPAA also would affect any cost estimate of a future fee increase. In order to comply with HIPAA, the Department will need to standardize the local codes currently being used by Maryland providers. In some cases, the procedures used by Maryland's Medicaid program to reimburse for certain services differ significantly from the new standard to which Maryland must convert. One example is the method by which Maryland's Medicaid providers bill for anesthesia services. The Department currently bases anesthesia reimbursement rates upon the type of procedure being performed. In order to comply with HIPAA, the Department must base reimbursement upon the amount of time the service is performed. At this stage of the HIPAA conversion process, the Department cannot fully anticipate how the fee schedule and future expenditures will be affected.

Finally, the characteristics of the Medicaid population would affect the cost of increasing physician fees. Any estimate would need to be re-evaluated should there be any unanticipated increase in enrollment or significant shift in the demographics of the enrolled population.

Given these limitations, the Department can provide only partial and preliminary estimates of the cost impact of further increases in physician fees. The cost of increasing reimbursement for those non-Evaluation and Management codes (other than radiology and laboratory services) for which the Medicare fee schedule contains an exact match to a level that is equal to 80 percent of the 2002 Medicare fee schedule is approximately $45 million (Total Funds). This does not include the cost of increasing the fees for which there is not a matching Medicare fee or for the conversion of certain fees under HIPAA, as described above.

Appendix 1
Medicare Resource Based Relative Value Scale[4]

Medicare payments for physician services are made according to a fee schedule. The fee schedule determines relative weights (relative value units) for all procedures. These weights reflect resource requirements of each procedure performed by the physicians.

For about 10,000 physician services, Medicare RBRVS assigns the associated relative value units and various payment policy indicators needed for payment adjustment. The Medicare physician fee schedule amounts are adjusted to reflect the variations in practice costs from area to area. A geographic practice cost index (GPCI) has been established for every Medicare payment locality for each of the three components of a procedure's relative value unit (i.e., the RVUs for work, practice expense, and malpractice). The GPCIs are applied in the calculation of a fee schedule payment amount by multiplying the RVU for each component by the GPCI for that component.

The resulting weights are multiplied by a conversion factor to determine the payment for each procedure. The Centers for Medicare and Medicaid Services (CMS), formerly the Health Care Financing Administration (HCFA), annually updates the conversion factor based on a formula designed to control overall spending while accounting for factors that affect the costs of providing care.

Calculating the update to the conversion factor is a two step process. First, CMS estimates the Sustainable Growth Rate (SGR). The SGR is the target rate of growth in total Medicare spending for physician services. SGR is a function of the percentage changes in:

a) Input prices for physician services,
b) Traditional (fee-for-service) Medicare enrollment,
c) Real Gross Domestic Product per capita, and
d) Spending attributable to changes in law and regulations.

The second step in the process is to calculate the update to conversion factor. This update is a function of:

a) Change in Medicare Economic Index (MEI) which measures the change in input prices for producing physician services.
b) An adjustment factor that increases or decreases the update as needed to align actual spending with the SGR target, and
c) Other adjustments, such as budget neutrality adjustments required by law.

The Conversion Factor for 1999 was $34.7315. The conversion factor for year 2000 was $36.6137. The conversion factor for 2001 is $38.2581, which represents a 4.5 percent increase over the year 2000 conversion factor. The conversion factor for 2002 decreased by 5.4 percent from its 2001 value to $36.1992.

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[4] Source: Health Care Financing Administration and Medicare Payment Advisory Commission publications.

References

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