The following document is a draft report of the Prince George's Hospital System Improvement Task Force. Its posting on this website should not be construed as DHMH's endorsement of the Task Force's findings and recommendations. DHMH is posting this document in the interest of enhancing its availability to the public. A public hearing on the draft report will be held on December 18, 6:30 pm, at the auditorium of the Prince George's Hospital Center. For more information, contact Robyn S. Elliott, staff to the Task Force, at 410-767-5867.

# The Prince George's Hospital System Improvement Task Force

Draft Final Report on

Ensuring the Long-Term Viability of
The Prince George's Hospital System
An Analysis and Recommendations

Dr. George C. Malouf, Chair

December 2002

## I. Origin of the Task Force

Dimensions Hospital System plays a vital role in ensuring the health of the residents of Prince George's County and surrounding jurisdictions. For the past several years, the System has been facing serious financial difficulties. Out of concern about the impact of these difficulties on the State, the Maryland General Assembly enacted Chapter 342, Acts of 2002, to establish the Prince George's Hospital System Improvement Task Force. The purpose of the Task Force is to identify strategies that will help the System achieve long-term financial stability. Chaired by Dr. George S. Malouf, the Task Force consists of 22 members, who were selected because of their expertise in finance, health care, or State and local government (see Attachment I for complete membership list).

## II. The Work of the Task Force

The Task Force is required by statute to issue its final report by September 2004. As the first order of business, the Task Force decided to complete its work much earlier, given the pressing nature of Dimension's financial difficulties. This final report, completed in December 2002, should be timely enough to provide guidance to newly elected officials on the local and State levels. The Task Force plans to monitor the implementations of its recommendations for the remainder of its existence.

The Task Force began its work by holding a series of meetings to hear from the major stakeholders in the process, including Dimensions Health Care System, University of Maryland Medical System, and the Prince George's County Executive Office (see Attachment II for complete list of presenters). These stakeholders provided useful information on Dimensions itself and the climate in which it operates. Topics of discussion included the hospital rate-setting system, uncompensated care, and the nursing shortage.

Following the presentation of major stakeholders, the Task Force members conducted independent research into the pertinent issues. With the findings from this research, the members developed their recommendations. These draft recommendations will be presented at a public hearing on December 18, 2002.

## III. The Importance of Dimensions' Role in the Community

As the largest provider of inpatient and emergency services in the county, Dimensions is a cornerstone in the health care system of Prince George's County. However, its importance extends beyond county borders. Residents of surrounding jurisdictions rely on many of Dimensions' services, particularly emergency care. Therefore, access to quality health care for the whole region depends on the continuation of Dimensions' services. In the past fiscal year, Dimensions has been the primary provider of care to:

- 22,614 individuals who need surgery or other medical care in an inpatient setting;
- 130,748 individuals who require emergency care, including 2,500 individuals at the only Level II trauma center in the region;
- the majority of the uninsured and Medicaid beneficiaries who need inpatient and emergency room services;
- the majority of high-risk pregnant women and infants, given that Dimensions has the only Level III NICU and perinatal diagnostic center in the area; and
- 16,670 individuals who require ambulatory surgery.

## IV. History of Dimensions Health Care System

Dimensions Health Care System is a 501(c)(3) non-profit which includes (see Attachment III for complete organizational chart):

- Prince George's Hospital Center (PGHC), a 284 bed acute care hospital;
- Laurel Regional Hospital (LRH), a 107 bed acute care hospital;
- Bowie Health Center (BHC), an ambulatory surgery and emergency room facility; and
- Full and partial ownership in several long-term care facilities.

Although Dimensions is now a private non-profit organization, the hospital system has a long history of being a county-owned entity. In 1970, Prince George's County adopted a charter to make Prince George's Hospital Center, then a private community hospital, into a county department. Shortly thereafter, the County expanded its service capacity by building LRH and the BHC.

In 1983, the County made its first attempt to move away from direct management of the hospital system. A 10-year lease was negotiated with Community Hospitals and Health Care System (CHHCS). However, CHHCS came close to collapse. Local officials stepped-in and helped restructure the system. With a reconstituted board, the name of the system was changed to Dimensions.

Dimensions negotiated with the County for a one-time payment of $10 million and an annual subsidy of $2.5 million for indigent care. The annual subsidy, subject to review and the availability of funding, was established so that Dimensions could continue to serve individuals in need.

Dimensions, as CHHC had, leased all its facilities and grounds from the County. In 1992, Dimensions extended the term of the lease to 2042, with a one-time payment of $13.3 million from a bond issuance and $1 annual lease payment (See Attachment IV for a detailed analysis of Dimensions' relationships with its bond trustees and Prince George's County).

The County ended its annual indigent care payment to Dimensions in 1994, although the payment has remained an option under the lease agreement. Dimensions initially could sustain itself without this subsidy because the system was in good financial health. However, the financial tide began to turn for Dimensions in the late 1990's. Like many other providers, Dimensions has struggled to adjust to major changes in the health care system. Throughout these difficult times, the hospital system has remained committed to ensuring all individuals in need have access to care.

As a result of its financial difficulties, Dimensions is exploring a potential sale or merger with another hospital system. Such a transaction could bring in an infusion of funds. Dimensions is now reviewing proposals from six hospital systems. Once the review has been completed in early 2003, more details will be known about the impact of a potential sale or merger.

## V. Dimension's Current Financial Status

Dimensions experienced $45.8 million in operating losses between fiscal 1999 and 2002, as shown in **Exhibit I**. To cover these losses, Dimensions used

**Exhibit I**
**Dimensions Health Care System**
**Consolidated Statement of Revenues and Expenses**
**($ in Thousands)**

| | FY 1999 Audited | FY 2000 Audited | FY 2001 Audited | FY 2002 Audited | FY 2003 Budget |
|---|---|---|---|---|---|
| **Revenue** | | | | | |
| **Patient Revenue** | | | | | |
| Gross Patient Revenue | $251,143 | $255,377 | $284,828 | $314,619 | $323,602 |
| Contractual Allowances | ($13,895) | ($15,201) | ($19,509) | ($21,933) | ($22,041) |
| Physician Fee Allowance | (704) | (1,291) | (1,979) | (4,113) | (3,983) |
| Bad Debts & Charity | (35,814) | (38,778) | (35,001) | (34,190) | (35,472) |
| **Net Patient Revenue** | **$200,730** | **$200,107** | **$228,339** | **$254,383** | **$262,106** |
| **Other Operating Revenue** | | | | | |
| Other Revenues | 8,682 | 6,601 | 7,111 | 12,733 | 8,094 |
| Investment Income | 651 | 624 | - | - | - |
| **Total Other Operating Revenue** | **$9,333** | **$7,225** | **$7,111** | **$12,733** | **$8,094** |
| **Non-Operating Investment Income** | **$2,202** | **$1,898** | **$1,074** | **$1,671** | **$480** |
| **Total Operating and Non-Operating Revenue** | **$212,265** | **$209,230** | **$236,524** | **$268,787** | **$270,680** |
| **Expenses** | | | | | |
| **Operating Expenses** | | | | | |
| Salaries | $99,803 | $100,277 | $111,252 | $121,101 | $122,270 |
| Employee Benefits | 16,616 | 16,039 | 15,227 | 17,352 | 19,461 |
| [1] Physician-Related Compensation | 9,937 | 11,216 | 12,820 | 13,663 | 14,567 |
| Supplies | 35,948 | 39,173 | 40,728 | 44,885 | 44,986 |
| Utilities | 3,284 | 3,431 | 3,517 | 3,473 | 3,855 |
| Purchased Services | 36,218 | 40,098 | 44,301 | 56,989 | 49,541 |
| **Total Operating Expenses** | **$201,806** | **$210,234** | **$227,845** | **$257,463** | **$254,680** |
| **Interest and Depreciation** | | | | | |
| Interest Expense | $5,803 | $5,680 | $5,669 | $5,397 | $5,329 |
| [2] Depreciation & Amortization | 11,587 | 11,300 | 10,891 | 10,629 | 10,421 |
| **Total Interest and Depreciation** | **$17,390** | **$16,980** | **$16,560** | **$16,026** | **$15,750** |
| **Total Operating Expenses** | **$219,196** | **$227,214** | **$244,405** | **$273,489** | **$270,430** |
| **(Deficit)/Surplus from Continuing Operations** | **($6,931)** | **($17,984)** | **($7,881)** | **($4,702)** | **$250** |
| **Gain/(Loss) from Discontinue Operations** | **($9,341)** | **$1,000** | **$0** | **$0** | **$0** |
| **(Deficit)/(Surplus) from Continuing and Discontinued Operations** | **($16,272)** | **($16,984)** | **($7,881)** | **($4,702)** | **$250** |

[1] Includes physician subsidies at PGHC, Laurel Regional Hospital and Bowie Health Center. The Task Force identified the physician subsidy at PGHC as one of the reasons behind Dimensions' financial difficulties.

[2] Depreciation mostly stems from 7-year depreciation on equipment.

Source: Dimensions HealthCare Systems Audited Financial Statements

its cash reserves and the subsidies from the County and State. This effort has drained Dimensions' rainy day resources. As of the end of October 2002, Dimensions only had 9 days of cash on hand.

Dimensions may reverse the trend of severe operating losses in fiscal 2003 with a positive margin of $250,000, as shown in the budgeted projections under Exhibit 1. This positive margin could fall if projected revenues are lower or projected expenses are higher. The modest improvement in Dimensions budget projections is the result of several key actions taken by the hospital system:

- **Contract with Cap Gemini:** Dimensions recognized that its bottom line could be improved by more efficient management. To identify operational improvements, Dimensions contracted with Cap Gemini, a nationally-known management consulting firm. Cap Gemini has helped Dimensions to enhance collection of patient revenue and reduce expenditures through efficiency measures.

- **Working with the Health Services Cost Review Commission (HSCRC):** Since 1974, the HSCRC has regulated the rates of all hospitals in Maryland. This rate-setting system has benefited hospitals because it provides for more stability in revenues. When Dimensions began experiencing financial difficulties, it appealed to the HSCRC for financial relief. The HSCRC worked with Dimensions to enhance rates at PGHC, which has been hit hardest by operating losses:

    - After a full rate review in fiscal 2001, the HSCRC agreed with Dimensions that PGHC's overall rate structure was not sufficient. The HSCRC allowed PGHC to raise its rates by almost 4%, in addition to an annual inflation factor.

    - The HSCRC recognized that PGHC has one of the largest shares of uncompensated care in Maryland. To help PGHC recoup some of its lost revenue, the HSCRC allowed the hospital to raise its rates by another 3.9%. However, the revenue from this rate increase only covers a portion of PGHC's losses. Therefore, the HSCRC covers the remaining losses with an annual grant of about $12 million from the Uncompensated Care Fund, which is collected from hospitals across the state.

- **Initiating Partnerships with the County and State:** Facing severe cash-flow problems, Dimensions reached out to its partners in County and State Government. In fiscal 2002, Dimensions was able to secure $3 million from the County and $2.5 million from the State. Without these funds, the operating losses shown in Exhibit 1 would have been

more severe. If the County provides a $3 million match in fiscal 2003, the State is willing to renew its commitment with another $2 million.

Despite the modest improvements in Dimensions' projections for fiscal 2003, the hospital system is still in a very tenuous financial position. The projected profit margin cannot begin to meet Dimensions' most pressing needs. Dimensions will still be left without the funds to make much needed investments in staff, facility improvements, and equipment. More long-term debt, at this point, is not an option given that Dimension's percent of debt to total capitalization has already reached 81%.

If there is an unexpected drop in revenue or increase in expenses, Dimensions will soon be facing a negative operating margin again. It would be very challenging for Dimensions to address ongoing losses, given that it has already used much of its rainy day reserves.

## VI. Reasons Behind Dimensions' Ongoing Financial Difficulties

Dimensions' financial difficulties are the result of ongoing problems within its system and the greater operating environment. These problems were exacerbated in the late 1990's by one-time only losses stemming from the failure of Prime Health, a Medicaid managed care organization, and the divestment of group medical practices. Dimensions acknowledged that the purchase of group practices did not benefit the system as expected, but many other hospital systems had similar strategies at the time.

The problems still facing Dimensions include: 1) a uniquely competitive market; 2) difficulty in building a medical and health professional staff for the future; 3) the need to subsidize physicians; 4) lack of access for capital funding; and 5) an inflexible governance structure;

### A. Difficulties in Maintaining Market Share in a Uniquely Competitive Market

Dimensions operates in a very aggressive health care market. The system is surrounded by highly competitive hospitals in Prince George's County, the District of Columbia, Montgomery County, Anne Arundel County, and Baltimore City (see Attachment V for map of competitors).

Most of Dimensions competitors have far better facilities and equipment. Some even have nationally-renowned clinical programs. This makes it difficult for Dimensions to attract patients and maintain its market share. Dimensions also has difficulty in competing for managed

care contracts because PGHC has relatively high rates because of the increase built-in to recoup some of its uncompensated care losses.

## B. Difficulty in Building a Strong Patient Base with a Solid Physician Network

A strong patient base in the backbone of any viable health care system. This base depends on referrals from a solid physician network. Dimensions' because many members of its physician network are near retirement. The hospital system is experiencing great difficulty in recruiting new physicians because its competitors have better facilities and payor mixes.

Dimensions is also having difficulty recruiting and retaining other health care professionals, particularly nurses in this time of nursing shortages. Many employers in the area offer more competitive compensation packages.

## C. The Need for Physician Subsidies

Dimensions has continued its commitment to ensuring that the most vulnerable citizens have access to medical care. As a result, Dimensions has one of the more unfavorable payor mixes in the State. Dimensions estimates that it shoulders 78% of the uncompensated care burden in the county, with most of that care provided by PGHC. This fact is reflected in PGHC's payor mix, which is 22.5% uninsured, 28.8% Medicaid or Medicaid pending, and 48.7% other major payors. With this payor mix, Dimensions must provide an $11 million annual subsidy to its physicians at PGHC. This subsidy drains resources that could otherwise be used for much needed capital improvements.

There has been some relief from the need to subsidize physicians with high Medicaid caseloads. Under the leadership of Secretary Georges C. Benjamin, M.D., the Department of Health and Mental Hygiene (DHMH) recently implemented the first step of a rate enhancement plan for Medicaid physicians, with the approval of Governor Glendening and the General Assembly (see Attachment VI for DHMH's plan). The first step focuses on fee increases for primary care physicians, thus reducing the need to subsidize those physicians. However, Dimensions will still need to provide a full subsidy to its specialty physicians because they do not receive fee increases on the first step of the plan.

The Medicaid fee increase partially addresses the need to subsidize physicians with high Medicaid case loads, but they do not address the problem of uncompensated care. While the HSCRC rate-setting system

shields hospitals from unfavorable payor mixes, it does not protect physicians because of restrictions in federal statutes.

**D. Lack of Access to Capital Funding**

Dimensions needs capital funding to update facilities and equipment. Without these improvements, Dimensions cannot build its physician and patient bases. However, Dimensions' ability to borrow capital funding is limited because of its inadequate operating margin, insufficient liquidity, and high debt to capital ratio.

Dimensions has a high debt ratio because the County still owns all of Dimensions' facilities and grounds. Without these assets, Dimensions' debt to equity ratio is too high to secure favorable bond ratings, as shown in **Exhibit 2**:

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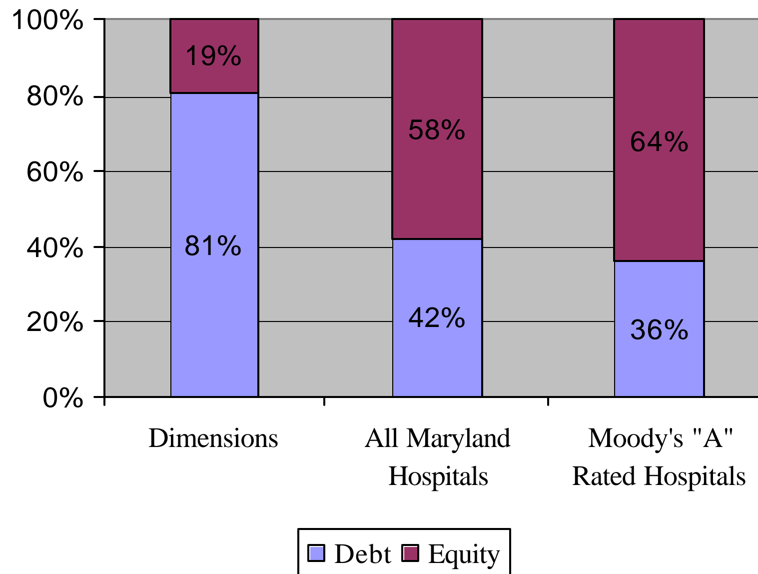
**Exhibit 2**
**% of Debt to Total Capitalization**




Source: University of Maryland Medical System

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With such a high debt to equity ratio, Dimensions cannot easily access any additional long-term debt. Moody's has downgraded Dimensions to B-.

**E. An Inflexible Governance Structure**

Dimensions' board has oversight of every facility in the hospital system. Each facility has a separate board that advises the members of Dimensions' board. The facility boards do not have the ultimate authority over facility operations. Only the Dimensions' board can make final decisions.

The structure of Dimensions' board is mandated by the terms of the hospital system's lease agreement with the County. The lease requires that 8 of the 11 seats on the board be filled by representatives of the following stakeholders: the PGHC Board, the LRH Board, the BHC Board, the Prince George's County Medical Society, PGHC medical staff, LRH medical staff, the Prince George's County Executive Office, and the Prince George's County Council.

The composition of the board does not include enough outside community and business leaders. As a result, Dimensions has experienced difficulty in building a broad base of support. Dimensions needs this support in facing its current financial challenges.

## VII. Task Force Recommendations about Dimensions

As required by statute, the Task Force's goal is to identify possible solutions to assist the hospital system in achieving success. This success is essential in ensuring that residents of Prince George's County and surrounding jurisdictions continue to have access to quality health care.

The hospital system needs a sufficient level of operating funds in the short-run, but the hospital system's long-term survival depends on capital funding. Thus, the Task Force's recommendation addresses both the short- and long-term financing needs of the hospital system:

**<u>Recommendations on Short-Term Solutions</u>**

1. **Funding for Short-Term Operating Needs:** In fiscal 2002, the hospital system received $2.5 million from the State and $3 million from the County. The funding commitment was in recognition that the hospital system's financial viability is critical to ensuring access to quality

care. The State has continued its commitment with another $2 million in fiscal 2003. To draw-down these State funds, the hospital system must receive a matching commitment of $3 million from Prince George's County. **The Task Force recommends that Prince George's County provide the $3 million in matching funds, given that an annual indigent payment is already an option under the current lease agreement. Once these matching funds are provided, the Task Force recommends that the Maryland General Assembly release the State funds for the hospital system, in accordance with the provisions of the Fiscal 2003 Budget Bill. The Task Force strongly recommends that both the County and State grants be used by the hospital system exclusively to fulfill its mission to the public.**

**Recommendations on Long-Term Solutions**

1. **Enhancing Access to Long-Term Debt:** When the hospital system became a private entity, the County retained ownership of the grounds and facilities. This arrangement has severely restricted the hospital system's ability to obtain long-term debt and make necessary capital improvements. This problem was avoided in other public-to-independent non-profit conversions by transferring ownership of the assets to the private entity, on the basis that the private entity would continue its commitment to the public. **The Task Force recommends that Prince George's County and the hospital system develop an agreement to transfer ownership of its assets by July 1, 2003. Transferring assets will give the hospital system the flexibility to restructure capital debt, enhance its position in the bond market, and ultimately create more opportunities for financial solvency. If the assets are transferred, the lease between the hospital system and the County will be dissolved. It is understood that any changes would not impact the security interests of existing bondholders.**

2. **Ongoing Operating Support:** Under the current lease agreement, Prince George's County has the option of making an annual indigent care payment to the hospital system. The hospital system will continue to need this support, even if the lease agreement is dissolved because of an asset transfer. **While the lease arrangement continues,**

**the Task Force recommends that Prince George's County renew its commitment to an annual indigent care payment to the hospital system. If the lease agreement is dissolved, the County should continue this commitment for at least three years to assist the hospital system in achieving long-term financial stability. The hospital system should demonstrate how it will achieve this stability in a long-term financial plan.**

3. **Obtaining Capital Support from the County and State:** Even if the assets are transferred, the hospital system will need capital support from the County and the State. This capital support has been an important factor in the success of other public-to-independent non-profit conversions. The hospital system, like similar institutions in Maryland, needs capital support because it provides a high-volume of services to the most vulnerable individuals – the uninsured, Medicaid beneficiaries, and trauma patients from many jurisdictions. **The Task Force recommends that the County and State assist the hospital system with its long-term capital needs, given that capital support has been an important factor in other successful public-to-private conversions. The hospital system needs this capital support to continue its mission to serve the public. The hospital system should work with the County and State to develop a long-range capital plan.**

4. **Examining Sale and Merger Opportunities:** A sale or merger could provide the hospital system with a much needed infusion of funding. **If the hospital system continues to explore any sale or merger options, the Task Force recommends that the hospital system should only consider proposals that are from entities with a proven track record that can ensure that: 1) the system will continue its mission of serving those most in need. Without the hospital system's services, many uninsured individuals and Medicaid beneficiaries would have great difficulty in accessing quality health care; 2) the system will continue to deliver quality care to all its clients; and 3) good management practices will keep the system financially viable.**

5. **Restructuring the Hospital System's Board to Build More Community Support**: The board's structure is mandated by the terms of the hospital system's lease agreement with Prince George's County. As the result of the inflexibility of this lease agreement, the board does not include the most important stakeholders in the community. **The Task Force recommends that the hospital system board be restructured. If the lease remains, the agreement should be amended to expand the board and minimize the number of designated seats. If the lease is terminated, then there should be a new board materially larger than the current board and without a significant number of designated positions. In either event, there should be substantially new board membership. Recruitment should build a board of extraordinary quality that is focused on the hospital system's fiscal health. New members should facilitate the following: 1) the hospital system's ability to build strong relationships with business leaders, community groups, and elected officials on the local and State level and 2) the board's consideration of community needs in making management decisions.**

6. **Developing a Long-Term Clinical Services Plan:** The hospital system has made some short-term financial progress by implementing Cap Gemini's recommendations on enhancing patient revenue collections and increasing efficiency. To ensure financial viability in the long-run, the hospital system needs a strategic clinical services plan with a strong marketing component. **Therefore, the Task Force recommends that the Board make the development of a long-term clinical services plan a top priority. To strengthen its clinical services, the hospital system should explore affiliations with other health care entities, particularly academic medical centers. During the planning process, the Task Force recommends that the hospital system work with the Maryland Health Care Commission to determine unmet health care needs and identify potential Certificate of Need Opportunities.**

7. **The Study Panel on the Funding Needs of Trauma Centers:** The General Assembly established the study panel to examine the operating budget needs of the regional trauma centers in Maryland. Dimensions, like other

hospital systems with trauma centers, struggles to provide around-the-clock coverage. **Therefore, the Task Force recommends that the Study Panel consider the hospital system's needs in developing funding solutions for regional trauma centers. During the 2003 legislative session, the Governor and General Assembly should carefully consider the Study Panel's recommendations, given the importance of ensuring that all residents of the State have quick access to high-quality emergency care. There should also be consideration that a closer affiliation between the hospital system and an academic medical center could strengthen the trauma system.**

8. **Working with the HSCRC to Develop an Optimal Rate Structure:** The hospital system has worked closely with the HSCRC on rate issues. The HSCRC has allowed Dimensions to raise PGHC's rates to cover its operating losses, particularly in the area of uncompensated care. However, the higher rates have a negative impact on Dimensions' ability to compete for managed care contracts. To prevent rates from being even less competitive, the HSCRC covers some of PGHC's losses with a grant from the Uncompensated Care Fund. **The Task Force recommends that the hospital system continue to work closely with the HSCRC to obtain a rate structure that strikes the right balance between rates that yield sufficient revenue and rates that are competitive. The HSCRC can assist the hospital system in identifying possible market competitiveness, market efficiencies, and the best method for recouping uncompensated care losses.**

9. **Enhancing Medicaid Rates:** To maintain its provider network, Dimensions must subsidize its physicians because they lose money from uncompensated care and low Medicaid rates. In fiscal 2003, Governor Glendening and the General Assembly supported the first step of a plan to raise Medicaid rates to a sufficient level. With their support, DHMH was able to update fees for primary care physicians, but little was done for specialty physicians. **The Task Force recommends the continued implementation of the Medicaid fee enhancement plan so that physicians do not have to rely on hospitals for subsidies.**

## VIII. Conclusion

Prince George's Hospital Center, Laurel Regional Hospital and the Bowie Health Center are the cornerstones of the health care system in the Prince George's County region. Access to quality care, particularly for individuals in need, depends on continuation of the hospital system's services. To ensure the future of those services, the Task Force urges that its recommendations be implemented expeditiously. Successful implementation will require a strong relationship between the hospital system and its partners in the public and private sectors. The hospital system, as well as the people it serves, needs the support of the Governor, General Assembly, Prince George's County Executive and Council, and other community leaders.

**Attachment I**
**Membership List**
**The Prince George's Hospital System Improvement Task Force**

Dr. George S. Malouf, Chair

The Honorable Dorothy Bailey

Dr. Georges C. Benjamin

Mr. Robert G. Brewer, Esquire

Mr. Robert A. Chrencik

Mr. Alvin C. Collins

The Honorable Ulysses Currie

The Honorable Wayne Currie

The Honorable Barbara A. Frush

Mr. Larry L. Grosser

Ms. Debra B. Humpries

Mr. Gary W. Michael

Ms. Shirley H. Morgan

Ms. Robin O. Oegerle

Mr. K. Mark Puente

Ms. Sylvia Quinton, Esquire

The Honorable Howard P. Rawlings

Ms. Sheila K. Riggs

Rev. Robert J. Williams

Ms. Phyllis Wingate-Jones

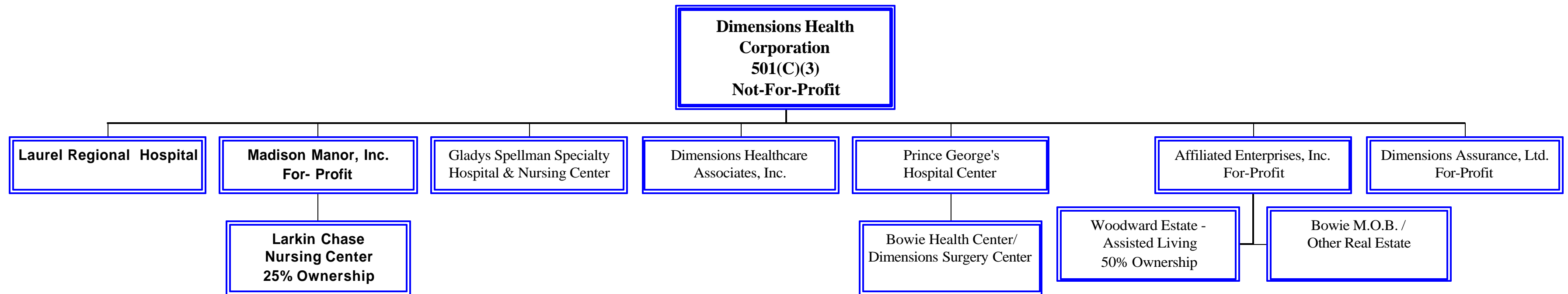
Dr. Melville Wyche

Staff: Uma Ahluwalia, Robyn S. Elliott, and Howard Cohen

## Attachment II
## List of Presenters to
## The Prince Georges Hospital System Improvement Task Force

Cap Gemini
City of Laurel Representative
Dimensions
Department of Budget and Management
Health Services Cost Review Commission
Maryland Hospital Association
Medical Staff Representative from Laurel Regional Hospital
Medical Staff Representative from Prince George's Hospital Center
Nursing Association at Prince George's Hospital Center
Prince George's Chamber of Commerce
Prince George's County Executive Office
Town of Laurel Representative
University of Maryland Medical System

# Attachment III
# Dimensions Health Systems Organizational Chart

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## 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

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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

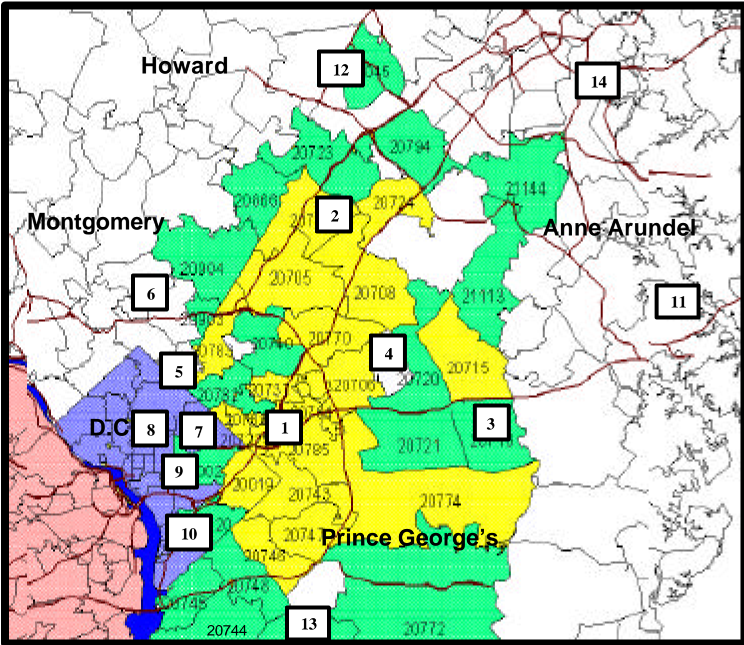
(2) Nonprofit Assets - maintaining the level of public benefit presumed to have been provided by the nonprofit organization prior to the conversion.

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**




1. Prince George's Hospital
2. Laurel Regional Hospital
3. Bowie Health Center
4. Doctor's Comm. Hospital
5. Washington Adventist
6. Holy Cross
7. Providence Hospital
8. Washington Hosp. Center
9. Howard University
10. Greater Southeast
11. Anne Arundel
12. Howard County General
13. Southern Maryland
14. North Arundel

**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 47$^{th}$ 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 <u>before</u> 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

American Academy Pediatrics: Medicaid Reimbursement Survey – 1998/1999 and 2001.

American Dental Association: 1999 Survey of Dental Fees (July 2000).

The Lewin Group: Comparing Physician and Dentist Fees among Medicaid Programs (June 2001). Prepared for Medi-Cal Policy Institute.