STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

John M. Colmers
Chairman

Herbert S. Wong, Ph.D.
Vice-Chairman

George H. Bone, M.D.

Stephen F. Jencks, M.D., M.P.H.

Jack C. Keane

Bernadette C. Loftus, M.D.

Thomas R. Mullen

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

Patrick Redmon, Ph.D.
Executive Director

Stephen Ports
Principal Deputy Director
Policy and Operations

Gerard J. Schmith
Deputy Director
Hospital Rate Setting

Mary Beth Pohl
Deputy Director
Research and Methodology

Post-meeting Documents
from the
497th MEETING OF THE HEALTH SERVICES COST REVIEW COMMISSION
May 1, 2013

EXECUTIVE SESSION
12:00 p.m.

1. **Waiver Update**
2. **Personnel Issues**

PUBLIC SESSION
1:00 p.m.

1. **Review of the Minutes from the Executive Session and Public Meeting Minutes from April 10, 2013 –** *approved*

2. **Executive Director's Report**
   - **Workgroups for Policy Development** *handout to Commissioners*
3. **Report on FY 2014 Update Factor Discussions**

   a. **Status of Work Groups to Develop Tools and Policies under Model Design Application**

4. **Docket Status – Cases Closed**

   2201A – University of Maryland Medial Center
   2202A – University of Maryland Medical Center

5. **Docket Status – Cases Open**

   2204N – St. Agnes Hospital – *approved*
   2205N – Harbor Hospital Center – *approved*
   2206A – Johns Hopkins Health System – *approved*
   2207A – Johns Hopkins Health System – *approved*

6. **Final Recommendation for Addressing Federal Sequestration –** *approved as amended*

7. **Final Recommendations on Shared Savings Policy –** *approved*
   - **MHA Medicare Readmissions** *handout*

8. **Final Recommendation on Technical Modifications to the Charge per Case/Charge per Episode Policy –** *approved*

9. **Final Recommendations for Continued Support of the Maryland Patient Safety Center –** *approved*

10. **Final Recommendation on Revised Electrocardiography Relative Value Units –** *approved*

11. **Draft Recommendation on FY 2014 Nurse Support Program II Competitive Institutional Grants**

12. **Hearing and Meeting Schedule**

Executive Session Minutes
Of the
Health Services Cost Review Commission

April 10, 2013

Upon motion made, Chairman Colmers called the meeting to order at 12:21 p.m.

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

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

Patrick Redmon, Steve Ports, Mary Pohl, Jerry Schmith, and Dennis Phelps attended representing staff.

Also attending were Joshua Sharfstein, Secretary of the Department of Health and Mental Hygiene, Patrick Dooley, the Secretary's Chief of Staff, as well as Leslie Schulman and Stan Lustman, Commission Counsel.

Item One

Chairman Colmers and Secretary Sharfstein discussed with the Commissioners the process, as well as some of the tasks and challenges facing the Commission in conjunction with a modernized waiver.

Item Two

The Commissioners discussed the Comfort Order process moving forward in light of the waiver modernization process.

The Executive Session was adjourned at 1:06 p.m.

MINUTES OF THE
496th MEETING OF THE
HEALTH SERVICES COST REVIEW COMMISSION

April 10, 2013

Chairman John Colmers called the meeting to order at 1:10 p.m. Commissioners George H. Bone, M.D., Stephen F. Jencks, M.D., M.P.H., Jack C. Keane, Thomas R. Mullen, Bernadette C. Loftus, M.D., and Herbert S. Wong, Ph.D. were also present.

REPORT OF THE EXECUTIVE SESSION OF APRIL 10, 2013

Dennis Phelps, Associate Director-Audit & Compliance, summarized the minutes of the April 10, 2013 Executive Session.

ITEM I
REVIEW OF THE MINUTES OF THE EXECUTIVE SESSIONS OF FEBRUARY 6, 14, AND 21, and March 6, 2013 AND THE PUBLIC MEETING OF FEBRUARY 6, 2013

The Commission voted unanimously to approve the minutes of the February 6, 14, 21, and March 6, 2013 Executive Sessions and the Public Meeting of February 6, 2013.

ITEM II
COMFORT ORDER – MEDSTAR HEALTH

The Commission voted unanimously to ratify the Comfort Order for MedStar Health approved in the Executive Session of March 6, 2013.

ITEM III
EXECUTIVE DIRECTOR'S REPORT

Patrick Redmon, Ph.D., Executive Director, reported that Monitoring Maryland Performance (MMP) indicated that the rate of growth in charge per case (CPC) decreased by 0.60% for the month of February 2013 versus February 2012. For the twelve months ending February 2013 versus the same period in 2012, CPC decreased 0.73%; inpatient revenue decreased 4.18%; the number of inpatient cases declined by 3.68%; outpatient revenue increased 12.75%; total gross revenue increased 1.89%, and for the twelve months ending February 2013 versus the same period in 2012, total gross revenue increased 1.42%.

Dr. Redmon stated that for the fiscal year-to-date ending February 2013, average operating profits for acute care hospitals was 0.85%. Dr. Redmon noted that according to hospital

representatives, an important factor to consider when looking at these operating profit numbers is that they may be overstated because they include funds from the Centers for Medicare and Medicaid Services' (CMS) Meaningful Use program.

Dr. Redmon noted that the Governor submitted the State's Model Demonstration proposal to the federal government on March 26, 2013. Dr. Redmon added that discussions with the Centers for Medicare and Medicaid Innovation (CMMI) concerning the Demonstration proposal continue.

Dr. Redmon announced that we will need to prepare for implementation of the new waiver in January 2014. This will require input from all constituents, representatives of hospitals, payers, staff, and the Department of Health and Mental Hygiene. In the next two weeks, a number of small work groups will be formed with defined tasks to focus on and prioritize the initiatives and policies necessary to implement the modernized waiver. These work groups will lay the groundwork for broader policy discussion before the Commission.

New Staff Members

Dr. Redmon introduced two new staff members, Elsa Hale and Erika McGowen. Ms. Hale is joining the staff as a Chief II for Quality Analysis. Ms. Hale has over ten years experience as an epidemiologist. Most recently, she was a Division Chief with the Department of Health and Mental Hygiene at the Division of Injury Epidemiology and Surveillance. Ms. Hale is a graduate of the University of Minnesota with a B.S. in Genetics/Cell Biology and a Masters Degree in Epidemiology from George Washington University.

Ms. McGowen is joining the staff as a Rate Analyst II. Ms. McGowen is a graduate of the University of Maryland-Baltimore County with a B.A. in Health Administration and Policy. Prior to joining the HSCRC, Ms. McGowen worked at Northrop Grumman in the Health IT division.

ITEM IV
PROCESS FOR FY 2014 UPDATE FACTOR DISCUSSIONS

Dr Redmon stated that since the effective date of the new waiver, if approved, will be January 1, 2014, staff will propose that an update factor with minimum policy changes be set for a "stub period," July 1, 2013 through December 31, 2013 under the current waiver. The first payment work group meeting will be held on April 19, 2013. Discussions will continue during May, with a draft recommendation presented at the June public meeting and a final recommendation at the July public meeting.

ITEM V
DOCKET STATUS CASES CLOSED

2168R – Garrett County Memorial Hospital 2193R – Adventist Behavioral Health

2200A – MedStar Health 2203N – Washington Adventist Hospital

ITEM VI
DOCKET STATUS CASES OPEN

University of Maryland Medical Center - 2201A

The University of Maryland Medical Center ("the Hospital") filed an application with the HSCRC on March 1, 2013 for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The Hospital requests approval from the HSCRC to continue to participate in a global rate arrangement for solid organ and blood and bone marrow transplant services with LifeTrac, Inc. Network for a period of one year, effective April 1, 2013.

Staff recommends that the Commission approve the Hospital's application. Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospital for the approved contract.

The Commission voted unanimously to approve staff's recommendation.

University of Maryland Medical Center – 2202A

On March 1, 2013, the University of Maryland Medical Center ("UMMC," or the "Hospital") filed an application with the Commission for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The Hospital has requested approval to continue to participate in a global rate arrangement with the Gift of Life Foundation (GOL) for the collection of bone marrow and peripheral blood stem cells from GOL on an outpatient basis, donors to facilitate Hematopoietic Stem Cell transplants into unrelated GOL recipients. The Hospital seeks approval of the arrangement for one year beginning April 1, 2013.

After reviewing the revised global rates and recognizing the efforts to reduce hospital charges through utilization reduction, staff recommends that the Commission approve the Hospital's application.

The Commission voted unanimously to approve staff's recommendation.

Extension

Staff requested a 30 day extension in the time to review proceeding 2205N – Harbor Hospital Center.

The Commission voted unanimously to approve staff's recommendation.

Staff Update – Adventist Behavioral Health – 2193R

As directed by the Commission, Jerry Schmith, Deputy Director-Hospital Rate Setting, advised the Commission of the uncompensated care (UCC) provision determined by staff to be appropriate for inclusion in the rates of Adventist Behavioral Health resulting from its full rate application approved at the February 6, 2013 public meeting. An increase in UCC was necessitated by the elimination of Purchase of Care funds provided by the State's Mental Hygiene Administration for the treatment of uninsured patients directed to the Hospital. The UCC provision determined to be appropriate by staff was 14.77%. This increase in the UCC provision, coupled with an increase in the reimbursement rate from the Medicaid program for its patients, will result in an additional increase in the Hospital's rates of 7.05% beyond the 4.33% previously approved by the Commission.

ITEM VII
DRAFT RECOMMENDATION FOR ADDRESSING FEDERAL SEQUESTRATION

Dr. Redmon summarized staff's draft recommendation for addressing federal sequestration (see "Impact of Sequestration and Options for the HSCRC – Draft Recommendation" on the HSCRC's website).

Staff's proposed recommendations were to: 1) make no change to hospital rates for fiscal year 2013; and 2) consider total revenue needs for hospitals, including the impact of sequestration, as part of the stub-period update factor discussions, assuming approval of the proposed demonstration model submitted to CMS/CMMI.

A panel consisting of Michael Robbins, Senior Vice President of the Maryland Hospital Association (MHA), Robert Crencik, President & CEO of the University of Maryland Medical System (UMMS), Stuart Erdman, Senior Director of Finance & Assistant Treasurer of the Johns Hopkins Health System (JHHS), and Bob Reilly, Chief Financial Officer of the Anne Arundel Health System (AAHS), presented comments on staff's draft recommendation.

Mr. Robbins requested on behalf of the hospital industry that the Commission take emergency action to include the full impact of sequestration into hospital rates immediately (see "MHA's Position on Sequester Action by the Health Services Cost Review Commission" on the HSCRC's website). According to Mr. Robbins, the effect of doing nothing would negatively impact already hospitals' already deteriorating operating margins. Mr. Robbins stated that the hospital industry would be happy to revisit this issue as part of the update factor for FY 2014.

Mr. Chrencik stated that the operating margins of the UMMS have dropped from 3% down to 1%. According to Mr. Chrencik, the difficult issue is unfunded inflation as a result of the low updates factors provided to hospitals. If you go back over the last four years and you accumulate the total unfunded inflation, it is about 5%. The deterioration in operating margins is now

beginning to affect access to capital. In addition, the new waiver will require Maryland hospitals to transform the way they do business. A key ingredient in making that happen will be acquiring new costly information technology (IT). The cash flow needed to purchase such equipment comes from operating margins. The industry needs the Commission's help by fully funding the sequestration to bolster hospitals' bottom lines before they are submitted to the bond rating agencies.

Mr. Reilly stated that in spite of the fact that Anne Arundel Medical Center (AAMC) has diligently worked to control non-salary costs over the last three years, AAMC's operating margin February year-to-date was 0.0%, and total margin was 0.9%. Because of sequestration AAMC may now be forced to reduce its workforce. Mr. Reilly urged the Commission to consider fully funding the sequestration revenue reduction immediately.

Mr. Erdman noted that Maryland hospitals are in a capital replacement cycle, replacing old buildings and acquiring costly IT systems at a time when hospitals are not getting revenue increases that even cover inflation. Bond rating agencies are not only watching Maryland hospitals closely, but they are also watching the HSCRC because of the waiver application and the low update factors. They are only concerned with the bottom line. Mr. Erdman also urged the Commission to consider fully funding the sequestration revenue reduction immediately.

John Hamper, Director-Provider Reimbursement of CareFirst of Maryland (CareFirst), stated that although CareFirst appreciates the hospitals position on profitability in regard to sequestration CareFirst does not consider this to be the vehicle or the time to make an adjustment. Sequestration is the federal government's attempt to reduce spending across the board. Any action that the Commission takes to dilute that savings would be inappropriate given the fact that we are negotiating the new waiver. Mr. Hamper, on behalf of CareFirst, urged the Commission to take no action on sequestration at this time.

Gary Simmons, Regional Vice President of United HealthCare (United), expressed support for CareFirst's position not to act on sequestration at this time. Mr. Simmons suggested that the appropriate time to address the sequestration issue is during the update factor process.

Chairman Colmers noted that if the payers' concern is harming Medicare, there are other ways to handle the sequestration, for instance increasing Medicare's differential. This would make hospitals whole; Medicare would receive its full savings, and the decrease in Medicare payments would be borne by all the other payers.

Commissioner Mullen in noting that, based on MHA and HSCRC, hospital revenue growth is at an all time low at 1%, asked whether CareFirst and United haven't, in fact, benefited.

Mr. Simmons pointed out that reductions in medical expenses reduce premiums and ultimately benefit the purchasers of healthcare coverage.

Commissioner Keane stated that he seemed to recall that in a previous presentation by United and CareFirst, they noted that they were being severely affected by substantial hospital outpatient

charge increases.

Chairman Colmers agreed with Commissioner Keane in that he remembered hearing a CareFirst official say there were 17% increases in each of the last two years in outpatient hospital charges.

The Commission decided to take no action on this issue at today's meeting.

Given the urgency expressed by the hospitals, Chairman Colmers urged the staff to provide to the Commission and to the public at large a reconciliation of the differences between CareFirst's and HSCRC's outpatient revenue growth and total revenue growth numbers as quickly as possible. The Chairman also requested that if the hospitals or payers had any additional material they wished to place before the Commission that they do so within the next seven days. Based on whether there is sufficient information before the Commission, a special meeting could be held if necessary.

ITEM VIII
STATUS REPORT ON ADMISSION-READMISSION REVENUE INTERVENTIONS AND OUTCOMES

Dianne Feeney, Associate Director-Quality Initiative, reported that in FY 2012, the HSCRC launched the Admission-Readmission Revenue (ARR) program to incentivize hospitals to reduce unnecessary readmissions to their facilities. Under the program, the 31 participating hospitals were required to create intervention plans aimed at reducing readmissions and to develop and monitor at least two metrics to evaluate intervention effectiveness. During FY 2012, the HSCRC collected ARR hospitals' intervention plans. The HSCRC staff collected the hospitals' metric results and conducted a qualitative survey of hospital experiences in ARR Year 1. Ms. Feeney stated that Julia Green, a Masters of Public Health candidate at the Johns Hopkins School of Public Health, conducted an analysis of the data and produced a paper discussing the findings (see "Status Report on Admission-Readmission Revenue Interventions and Outcomes" on the HSCRC website).

Ms. Green summarized the findings. The findings showed that discharge planning, scheduling follow-up appointments, and telephone follow-up were the most common types of intervention instituted by hospitals, while the metrics used to monitor program effectiveness were relatively diverse.

Ms. Green reported that based on an experience survey, approximately 50% of the hospitals found that implementation and monitoring of the interventions were difficult or very difficult. However, hospitals also reported that their new ARR measurement efforts helped them to understand the specific diagnostic categories of patients readmitted to their facility, develop more thoughtful discharge planning and care coordination programs, and guide quality improvement efforts.

According to Ms. Green, going forward few hospitals expect to make changes in the

interventions and metrics currently in place; however, about 40% of hospitals reported that they intended to develop new interventions or new metrics.

In terms of next steps, Ms. Feeney noted that the HSCRC will participate in collaborative efforts to improve interventions and outcomes, such as the Transitions: Handle with Care campaign. Ms. Feeney stated that the HSCRC will convene a work group to determine options for standardizing intervention plan and metrics reporting.

Commissioner Jencks asked Ms. Green and Ms. Feeney that if they had one lesson that they learned from the analysis of this data to give to Commissioner Mullen to take back to his hospital staff, what would it be.

Ms. Green stated that hospitals should focus on process metrics rather than outcome metrics.

Ms. Feeney stated that hospitals should look at the interventions that are successful at other hospitals and utilize them.

Commissioner Keane commended the report as being very well written.

ITEM IX
DRAFT RECOMMENDATIONS FOR MODIFICATIONS TO THE ADMISSION-READMISSION REVENUE (ARR) STRUCTURE

Mary Pohl, Deputy Director-Research and Methodology, described the current structure of the ARR program and explained why the program's structure must be modified in order for Maryland hospitals to be exempted from Medicare's Affordable Care Act readmissions reduction program (see "Draft Recommendation on Modifications to the Admission Readmission Revenue (ARR) Methodology" on the HSCRC website).

Ms. Pohl summarized proposed recommendations and modifications: #1) to move the ARR Program from voluntary agreements to Commission policy; #3a) reincorporate short stay cases into the ARR methodology, monitor the results of reincorporating the cases and adjust hospitals' revenue if warranted; and #3b) after input from the stakeholders, decide whether to exclude palliative cases from the Charge-per-Episode methodology.

Sule Calikoglu, Ph.D., Associate Director for Performance Measurement, summarized staff recommendation #2, incorporating a prospective, continuous improvement shared savings mechanism for FY 2014 rates.

Andy Udom, Associate Director-Research and Methodology, summarized staff recommendation #3c, to administratively simplify the statewide outlier trim logic.

No Commission action was required.

ITEM X
FINAL RECOMMENDATION ON PSYCHIATRIC CLINIC RELATIVE VALUE UNITS

Chris Konsowski, Assistant Chief-Audit & Compliance, presented a recommendation for final adoption of revisions to the Relative Value Unit (RVU) scale for Psychiatric Clinic services to be effective July 1, 2013.

The Commission voted unanimously to approve staff's recommendation.

ITEM XI
DRAFT RECOMMENDATIONS FOR CONTINUED SUPPORT OF THE MARYLAND PATIENT SAFETY CENTER

Diane Feeney, Associate Director-Quality Initiative, summarized the draft recommendations on Continued Financial Support for the Maryland Patient Safety Center (MPSC) for FY 2014 (see "Draft Recommendations on Continued Financial Support for the Maryland Patient Safety Center for FY 2014" on the HSCRC website).

Staff deferred making any recommendations on MSPSC's proposed projects and budget pending the completion of additional information gathering and analysis.

Robert Imhoff, III, President and CEO of MPSC, stated that MPSC's intent was to continue to pursue other sources of funding and gradually reduce the amount of support received from the HSCRC.

No Commission action was required.

ITEM XII
CONSIDERATION OF TWO REQUESTS FOR CONFIDENTIAL DATA

Claudine Williams, Associate Director-Policy Analysis and Research, presented staff's recommendation to approve Chesapeake Regional Information Systems' (CRISP's) request to access the HSCRC confidential inpatient and outpatient data patient level data for CY 2011 and CY 2012, as well as ongoing access to that data. The objective of this request is to support the transition to a population based approach to measuring and improving the performance of hospital and post-hospital care delivery systems.

Commissioner Mullen suggested that staff's recommendation be modified to state that CRISP shall not sell any reports that are produced relying on HSCRC data without the approval of the Commission.

The Commission voted unanimously to approve the modified recommendation.

Oscar Ibarra, Chief-Program Administration & Information Management, presented staff's recommendation to approve the U.S. Department of Health & Human Services, Assistant Secretary for Preparedness and Response, Biomedical Advanced Research and Development Authority's request to access the HSCRC confidential inpatient and outpatient patient level data for CY 2008 through CY 2012. The objective of this request is to study the impact of influenza on medical outcomes.

The Commission voted unanimously to approve staff's recommendation

ITEM XIII
LEGISLATIVE REPORT

Steve Ports, Principal Deputy Director-Policy & Operations, presented a summary of the legislation of interest to the HSCRC (see "Legislative Update-April 10, 2013" on the HSCRC website).

The following bills passed or had language added: 1) Senate Bill 151/House Bill 373 – Outpatient Services –Off-site Facility – Rate Regulation; 2) Senate Bill 195– Hospital – Notice to Outpatients - Outpatient Status and Billing Implications; 3) Senate Bill 274/House Bill 228 – Maryland Health Progress Fund; 4) House Bill 100 – FY 2014 Budget Bill; and 5) Senate Bill 127/House Bill 102 – Budget Reconciliation and Financing Act of 2013.

ITEM XIV
HEARING AND MEETING SCHEDULE

May 1, 2013	Time to be determined, 4160 Patterson Avenue, HSCRC Conference Room
June 5, 2013	Time to be determined, 4160 Patterson Avenue, HSCRC Conference Room

There being no further business, the meeting was adjourned at 4:35 p.m.

EXECUTIVE DIRECTOR'S REPORT
MAY 1, 2013

Monitoring Maryland Performance

For Year Ending February 2013

- Charge per Case decreased 0.52%
    - For the month of February 2013 versus February 2012, CPC increased 0.60%
    - For YTD ending February 2013 versus the same time period in 2012, CPC decreased 0.73%
- Cases (admissions + new born) decreased 3.68%
- Inpatient revenue decreased 4.18%
- Outpatient revenue increased 12.75%
- Total gross revenue increased 1.89%
    - For YTD ending February 2013 versus the same period in 2012, total gross revenue increased 1.42%.

Financial Condition

Data are available for profits for the eight months through February 2013 compared to the eight months through February 2012. For year-to-date ending February 2013, average operating profits for acute care hospitals was 0.85 percent. The median hospital had an operating profit of 0.98 percent, with a distribution as follows:

- 25^{th} percentile at -1.61 percent
- 75^{th} percentile at 5.10 percent

According to hospital representatives, an important factor to consider in these numbers is that Meaningful Use funds are included in these numbers as operating revenue and may overstate the usual operating revenue.

Progress on Demonstration Request

The Governor submitted the State's Model Demonstration proposal to the Federal government on March 26, 2013. Discussions continue with CMMI around details of the proposal.

Commission Staff are developing a series of Work Groups to discuss the key issues proposed in the Application. We are distributing a list of the Work Groups, timelines, and structure.

Workgroups for Policy Development

The staff will organize a series of small groups to work on the major policy initiatives to begin the process of implementing the model demonstration proposed to CMMI. Each workgroup would be relatively small to address the basic issues, with full-blown polices to be considered before the Commission. For transparency, the workgroups can reach out to others for input and allow observers of their discussions to permit an open process. The staff will seek additional expertise to support the committees' work.

For initiatives that do not require demonstration approval and make policy sense in the context of the current waiver, these initiatives can begin now. Others can only be implemented once Federal approval on the demonstration has been granted. The following is a proposed timeframe for these workgroups to begin the policy making process.

- Update factor
    - Stub period with minimal policy changes
    - Analysis of current waiver status
    - Analysis of industry financial conditions
    - Analysis of State Medicaid budget
    - Analysis of affordability for consumers
    - Analysis of impact of recommendation under per capita model proposed to CMMI
    - Timeframe
        - First meeting on April 19, 2013
        - Report to Commission at May 1, 2013 meeting on progress
        - Recommendation for June Commission meeting
        - Approval for June/July Commission meeting
    - Plan next steps for second half of fiscal year
    - Membership: staff, hospitals, payers, DHMH, consumer representatives

- Volume adjustment
    - Variable cost factor
        - Service differences (e.g., transplant services with high organ acquisition costs, hence high variable costs)
        - Regional differences
        - Recent CON approved projects' transition
        - Distributional issues (see population-based ROC below)
        - Analysis of volume growth and developing predictive modeling
    - Capital policy under enhanced volume adjustment
    - Timeframe for policy development
        - Begin work in May, 2013
        - Plan recommendation for January 2014, assuming approval of proposed model demonstration
    - Membership: staff, hospitals, payers, DHMH

- Lockbox savings
  - ARR
    - Development of current policy underway. How can it be attributed toward lockbox savings?
  - TPR
    - Negotiation of phase II is underway. How can results be attributed toward lockbox savings?
  - Population-based ROC
    - Reductions to inefficient institutions to be identified.
    - Methods for attributing savings to lockbox.
  - Timeframe for policy development
    - Begin work for ROC in July 2013
    - Plan for recommendation by January 2014, assuming approval of model demonstration
  - Membership: Staff, hospitals, payers, DHMH

- Gain sharing
  - Bundled payments
  - All-payer ACO model
  - Other models
  - Timeframe for policy development
    - Begin preplanning work in July 2013 to lay groundwork
    - Accept hospital requests for bundling and ACOs upon approval of model application
  - Membership: staff, hospitals, payers, DHMH, physician representatives

- Performance measurement
  - Measures
    - Per capita spending
    - Per beneficiary Medicare payments
    - Quality measures
  - Data requirements
    - HSCRC data
      - Reporting changes
      - Additional data
    - Medicare data on a more timely basis
    - Medicaid
    - All-payer data base
    - CRISP data utilization
  - Timeframe
    - Begin work in May 2013
  - Membership: staff, hospitals, payers, DHMH, MHCC, consumer representatives

H.S.C.R.C's CURRENT LEGAL DOCKET STATUS (OPEN)

AS OF APRIL 18, 2013

A: PENDING LEGAL ACTION : NONE
B: AWAITING FURTHER COMMISSION ACTION: NONE
C: CURRENT CASES:

Docket Number	Hospital Name	Date Docketed	Decision Required by:	Rate Order Must be Issued by:	Purpose	Analyst's Initials	File Status
2204N	St. Agnes Hospital	3/5/2013	5/4/2013	8/2/2013	HYP	CK	OPEN
2205N	Harbor Hospital Center	3/22/2013	5/21/2013	8/19/2013	ORC	CK	OPEN
2206A	Johns Hopkins Health System	4/10/2013	N/A	N/A	ARM	DNP	OPEN
2207A	Johns Hopkins Health System	4/12/2013	N/A	N/A	ARM	DNP	OPEN

NONE

PROCEEDINGS REQUIRING COMMISSION ACTION - NOT ON OPEN DOCKET

IN RE: THE PARTIAL RATE	*	**BEFORE THE HEALTH SERVICES**
APPLICATION OF	*	**COST REVIEW COMMISSION**
ST. AGNES	*	**DOCKET: 2013**
HOSPITAL	*	**FOLIO: 2014**
BALTIMORE, MARYLAND	*	**PROCEEDING: 2204N**

Staff Recommendation

Approved May 1, 2013

Introduction

On March 5, 2013, St. Agnes Hospital (the "Hospital") submitted a partial rate application to the Commission requesting a rate for Hyperbaric (HYP) services. The Hospital requests that the HYP rate be set at the lower of a rate based on its projected costs to provide HYP services or the statewide median and be effective April 29, 2013.

Staff Evaluation

To determine if the Hospital's HYP rate should be set at the statewide median or at a rate based on its own cost experience, the staff requested that the Hospital submit to the Commission all projected cost and statistical data for HYP services for FY 2013. Based on information received, it was determined that the HYP rate based on the Hospital's projected data would be $358.97 per hour of treatment, while the statewide median rate for HYP services is $312.34 per hour of treatment.

Recommendation

After reviewing the Hospital's application, the staff recommends as follows:

1. That a HYP rate of $312.34 per hour of treatment be approved effective April 29, 2013;
2. That no change be made to the Hospital's Charge per Episode standard for HYP services; and
3. That the HYP rate not be rate realigned until a full year's cost experience data have been reported to the Commission.

.

IN RE: THE PARTIAL RATE	*	**BEFORE THE HEALTH SERVICES**
APPLICATION OF	*	**COST REVIEW COMMISSION**
MEDSTAR HARBOR	*	**DOCKET: 2013**
HOSPITAL	*	**FOLIO: 2015**
BALTIMORE, MARYLAND	*	**PROCEEDING: 2205N**

Staff Recommendation

Approved May 1, 2013

Introduction

On March 22, 2013, MedStar Harbor Hospital (the "Hospital"), a member of MedStar Health, submitted a partial rate application to the Commission requesting a rate for Operating Room Clinic (ORC) services. The Hospital requests that the ORC rate be set at the lower of a rate based on its projected costs to provide ORC services or the statewide median and be effective May 21, 2013.

Staff Evaluation

To determine if the Hospital's ORC rate should be set at the statewide median or at a rate based on its own cost experience, the staff requested that the Hospital submit to the Commission all projected cost and statistical data for ORC services for FY 2013. Based on information received, it was determined that the ORC rate based on the Hospital's projected data would be $18.11 per minute, while the statewide median rate for ORC services is $15.89 per minute.

Recommendation

After reviewing the Hospital's application, the staff recommends as follows:

1. That an ORC rate of $15.89 per minute be approved effective May 21, 2013;
2. That no change be made to the Hospital's Charge per Episode standard for ORC services; and
3. That the ORC rate not be rate realigned until a full year's cost experience data have been reported to the Commission.

.

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION	*	**COMMISSION**	
JOHNS HOPKINS HEALTH	*	**DOCKET:**	**2013**
SYSTEM	*	**FOLIO:**	**2016**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2206A**

Staff Recommendation

Approved May 1, 2013

I. INTRODUCTION

Johns Hopkins Health System ("System') filed an application with the HSCRC on April 10, 2013 on behalf of Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center (the Hospitals) for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System requests approval from the HSCRC to continue to participate in a global rate arrangement for solid organ and bone marrow transplants services with INTERLINK Health Services, Inc. The System requests approval for a period of one year beginning July 1, 2013.

II. OVE RVIEW OF APPLICATION

The contract will continue to be held and administered by Johns Hopkins HealthCare, LLC ("JHHC"), which is a subsidiary of the System. JHHC will manage all financial transactions related to the global price contract including payments to the Hospitals and bear all risk relating to regulated services associated with the contract.

III. FEE DEVELOPMENT

The hospital portion of the global rates was developed by calculating mean historical charges for patients receiving the procedures for which global rates are to be paid. The remainder of the global rate is comprised of physician service costs. Additional per diem payments were calculated for cases that exceed a specific length of stay outlier threshold.

IV. IDENTIFICATION AND ASSESSMENT OF RISK

The Hospitals will continue to submit bills to JHHC for all contracted and covered services. JHHC is responsible for billing the payer and collecting payments, disbursing payments to the Hospitals at their full HSCRC approved rates, and reimbursing the physicians. The System contends that the arrangement among JHHC, the Hospitals, and the physicians holds the Hospitals harmless from any shortfalls in payment from the global price contract. JHHC maintains it has been active in similar types of fixed fee contracts for several years, and that JHHC is adequately capitalized to bear the risk of potential losses.

V. STAFF EVALUATION

Although there has been no activity under this arrangement, staff believes that the

Hospitals can achieve a favorable experience under this arrangement.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for solid organ and bone marrow transplant services, for a one year period commencing July 1, 2013. The Hospitals will need to file a renewal application for review to be considered for continued participation. Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospitals for the approved contract. This document would formalize the understanding between the Commission and the Hospitals, and would include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION	*	**COMMISSION**	
JOHNS HOPKINS HEALTH	*	**DOCKET:**	**2013**
SYSTEM	*	**FOLIO:**	**2017**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2207A**

Staff Recommendation

Approved May 1, 2013

I. INTRODUCTION

Johns Hopkins Health System (the "System") filed an application with the HSCRC on April 12, 2013 on behalf of Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center (the "Hospitals") for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System requests approval from the HSCRC for participation in a global rate arrangement for cardiovascular procedures with Quality Health Management for a period of one year beginning June 1, 2013.

II. OVERVIEW OF APPLICATION

The contract will be held and administered by Johns Hopkins HealthCare, LLC ("JHHC"), which is a subsidiary of the System. JHHC will manage all financial transactions related to the global price contract including payments to the Hospitals and bear all risk relating to regulated services associated with the contract.

III. FEE DEVELOPMENT

The hospital portion of the updated global rates was developed by calculating mean historical charges for patients receiving the particular cardiovascular procedures at the Hospitals. The remainder of the global rate is comprised of physician service costs. Additional per diem payments were calculated for cases that exceed a specific length of stay outlier threshold.

IV. IDENTIFICATION AND ASSESSMENT OF RISK

The Hospitals will submit bills to JHHC for all contracted and covered services. JHHC is responsible for billing the payer, collecting payments, disbursing payments to the Hospitals at their full HSCRC approved rates, and reimbursing the physicians. The System contends that the arrangement among JHHC, the Hospitals, and the physicians holds the Hospitals harmless from any shortfalls in payment from the global price contract. JHHC maintains it has been active in similar types of fixed fee contracts for several years, and that JHHC is adequately capitalized to bear the risk of potential losses.

V. STAFF EVALUATION

Although there has been no activity under this arrangement, the format utilized to calculate

the updated case rate, i.e., historical data for like cases, has been utilized as the basis for other successful cardiovascular arrangements in which the Hospitals are currently participating. Staff believes that the Hospitals can achieve a favorable experience under this arrangement.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for cardiovascular services for a one year period commencing June 1, 2013. The Hospitals will need to file a renewal application for review to be considered for continued participation. Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospitals for the approved contract. This document would formalize the understanding between the Commission and the Hospitals, and would include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.

Impact of Sequestration and Options for the HSCRC

Final Recommendation

May 1, 2013

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

This represents the recommendation as approved by the Commission on May 1, 2013.

Sequestration: What is it?

"Sequestration" is a process of automatic, largely across-the-board spending reductions under which budgetary resources are permanently canceled to enforce certain budget policy goals. It was first authorized by the Balanced Budget and Emergency Deficit Control Act of 1985 (BBEDCA, Title II of P.L. 99-177, commonly known as the Gramm-Rudman-Hollings Act). Recently, it was included as an enforcement tool in the Budget Control Act of 2011 (BCA, P.L. 112-25).

Two provisions were included in the BCA that result in automatic sequestration:

1. **Establishment of discretionary spending limits, or caps, for each of FY2012-FY2021.** If Congress appropriates more than allowed under these limits in any given year, sequestration would cancel the excess amount.
2. **Failure of Congress to enact legislation developed by a Joint Select Committee on Deficit Reduction ("Supercommittee"), by January 15, 2012, to reduce the deficit by at least $1.2 trillion.** The BCA provided that such failure would trigger a series of automatic spending reductions, including sequestration of mandatory spending in each of FY2013-FY2021, a one-year sequestration of discretionary spending for FY2013, and lower discretionary spending limits for each of FY2014-FY2021.

Because the Supercommittee failed to achieve its goal, the sequestration was scheduled to occur beginning in January 2013 and to cover the period through 2021 (Center for Budget and Policy Priorities). Legislation was enacted on January 2, however, that delayed the effective date until March 1, 2013 (P.L. 112-240). The automatic spending reductions affect both mandatory and discretionary spending and are equally divided between defense and nondefense spending (Congressional Research Service, 2013).

Sequestration Effect on Medicare

Medicare spending (excluding low-income and catastrophic subsidies for Part D and the qualifying individual program) is subject to sequestration, but the reduction to Medicare providers and plans cannot exceed 2 percent (approximately $11 billion in 2013), and Medicare beneficiaries will not face any direct reduction. The sequester reductions to certain other mandatory health programs, such as Indian Health, are also capped at 2 percent (bipartisianpolicy.org).

Effect of Medicare Payments Nationally

For payments made under Medicare Parts A and B, the percentage reductions are to be made to individual payments to providers for services (e.g., hospital and physician services). In the case of Parts C and D, reductions are to be made to the monthly payments to the private plans that administer these parts of Medicare. Reductions are to be made at a uniform rate and are not to exceed 2 percent. CBO estimates that Medicare benefit spending will be reduced by about $99.3 billion over the nine-year sequestration period (Congressional Research Service, 2013).

The budgetary baseline that must be used in implementing a sequestration has special implications with regard to Medicare. For direct spending, the baseline is to be calculated by assuming that the laws providing or creating direct spending will operate in the manner specified, and that funding for entitlement authority is adequate to make all required payments. Specifically, CBO's March 2012 projections of Medicare spending incorporated the assumption that Medicare spending would be constrained beginning in 2013 by the sustainable growth rate (SGR) mechanism used to calculate the fees paid for physicians' services. Those fees were to have been reduced by about 27 percent beginning in January 2013 and by additional amounts in subsequent years. However, the American Taxpayer Relief Act of 2012 (P.L. 112-240) overrode the scheduled reduction for FY2013; thus, spending for Medicare will be greater than the amounts projected in the baseline. CBO estimated a 10-year cost of freezing payments at current levels at close to $300 billion for 2012-2021; if payments were increased by a medical inflation factor, the cost could be even higher (Congressional Research Service, 2013).

Effect of Medicare Payments in Maryland

The last sequestration, resulting from the BBEDCA of 1985, reduced Medicare payments to hospital providers 2.092 percent from October 1989 through December 1989. The Medicare fiscal intermediary was to reduce charges by the full amount of the Medicare beneficiary's co-insurance and deductible (15 percent) and pay the remaining charges less 2.092 percent. In 1989, to recognize the reduction in Medicare revenue to the hospitals, the Commission voted to increase all rates by 0.8 percent and apply this adjustment at the time of the hospitals' next inflation adjustment as one-time money.

Today, the Commission is again faced with the question of how to address sequestration as it effects Medicare's payment of hospital charges in Maryland. There are several options available to the Commission. The next section outlines three possible options.

In this recommendation, we treat the options for the remainder of FY2013 only. While the duration of the sequester is uncertain at this stage, the immediate impact is for the current fiscal year, and the immediate policy necessity is to address that specific issue. Going forward, the impact of the sequester will be addressed as part of the update factor discussion for the proposed stub period from July 1 – December 30, 2013 and for the second half of the fiscal year, presuming approval of the State's proposed Demonstration Model.

Waiver Modeling

Staff modeled three possible options (Table 1) and their effect on the waiver cushion. The models below assume the following for FY2014:

- 0% update
- 0.42% increase to CPC due to the TPR methodology
- 0.62% increase to CPC due to the ARR methodology
- -.30% for ARR/TPR Shared Savings
- 2.00% increase due to reduction in 1DLOS cases
- 0.20% increase to CPC due to the full rate reviews and capital

Option 1: Hospitals held harmless

For this option, the Commission would treat the revenue lost from the sequestration as a one-time unusual expense. Hospital rates would reflect an increase of 0.64 percent annualized or 0.16 percent for the remainder of the fiscal year (April - June). If prices and volume remain constant, the resulting waiver cushion for YE J13 is forecasted to be 5.66 percent.

For FY2014 and forward, the sequester would be considered as part of the Commission's update factor discussion, taking into account the affordability of hospital services, the Medicare Waiver, and the financial condition of the State's hospitals. If the Commission were to continue to hold the hospitals harmless from the impact of sequestration in FY2014, we estimate that the waiver cushion would be 2.32 percent.

Option 2: 50/50 Split

For this option, the Commission would split the impact of the sequestration between payers and hospitals. In this instance, half of the sequestered revenue would be treated as a one-time expense and put into rates, resulting in a 0.32 percent increase to all rates annualized and 0.08 percent for the remainder of the fiscal year (April - June). If prices and volume remain constant, the resulting waiver cushion for YE J13 is forecasted to be 5.74 percent.

For FY2014 and forward, the sequester would be considered as part of the Commission's update factor discussion, taking into account the affordability of hospital services, the Medicare Waiver, and the financial condition of the State's hospitals. If the Commission were to continue the 50/50 split in FY2014, we estimate that the waiver cushion would be 2.73 percent.

Option 3: Payers held harmless

For this option, the Commission would require hospitals to absorb the full reduction to Medicare payments. If prices and volume remain constant, the resulting waiver cushion for YE J13 is forecasted to be 5.83 percent.

For FY2014 and forward, the sequestration would be considered as part of the Commission's update factor discussion, taking into account the affordability of hospital services, the Medicare Waiver, and the financial condition of the State's hospitals. If the Commission were to continue to hold the payers harmless from the impact of sequestration in FY2014, we estimate that the waiver cushion would be 3.14 percent.

Table 1: Options to Address Sequestration in Rates

	Medicare Payment Reduction to be Included in Rates	Annualized Impact on Rates	Estimated Waiver Cushion*	
			YE J13 with April - June Implementation of the Policy Option	YE J14 with Continued Implementation of the Policy Option
Option 1 : Hospitals held harmless	2.00%	0.64%	5.66%	2.32%
Option 2: 50/50 split between payers and hospitals	1.00%	0.32%	5.74%	2.73%
Option 3: Payers held harmless	0.0%	0.00%	5.83%	3.14%

**based CMS actuary information available and estimates made on 4/24/13*

Discussion

There are several items to consider in deciding the appropriate option. They include: financial condition of hospitals; affordability for consumers, private insurers, and taxpayers; and the status of the Medicare waiver.

For FY2013, the Commission approved an inpatient rate reduction of 1.25 percent with a budget for 0.25 percentage points for case mix growth industry wide and an outpatient increase of 2.59 percent. The overall impact on industry revenue at last year's volumes was an estimated 0.3 percent. The cumulative year to date revenue growth as of February 2013 is 1.42 percent.[1] Currently, the median total operating margin is 0.85 percent, with 30 hospitals showing positive total operating margins. Average profitability is down from the same period last year, when total operating margins were running at about 2.6 percent. This year, hospital total profits are 3.63 percent, up from 1.98 percent for the same period last year; 37 hospitals show positive total profits.[2]

Outside of Maryland hospitals may be able to shift some of these revenue losses to private payers, depending on their relative market power, thus offsetting some of the revenue losses. Maryland hospitals cannot do that under the State's rate-setting system. In the short run, however, hospitals nationally may have to bear the impact of this sequestration until contracts can be renegotiated, even if the losses can eventually be shifted.

Furthermore, while the status of the current waiver has improved somewhat from projections made at this time last year, the margin is still small compared to historic levels. Any partial sharing between hospitals and payers will erode that margin.

As the State continues its quest for a modernized waiver, the central issue of focus remains what Medicare and Medicaid spend in Maryland under the all payer system versus the rest of the nation. Action to restore the sequestered funds to hospital rates this year could be viewed upon negatively as part of federal consideration of the State's current request.

[1] Cumulative annual growth compares July 2012 to February 2013 growth to July 2011 to February 2012 growth.
[2] Profitability numbers from the consolidated unaudited financial statements with data as of February 2013.

Comments

The Commission has received many comment letters from hospitals and payers regarding the options proposed in the draft recommendation. The comment letters are attached. In its letter, CareFirst recommends Option #3 due to the waiver implications of imposing the other options, and the potential for diluting the intent of the sequestration. Many hospitals commented regarding their deteriorating financial condition and that they should be able to avail themselves of the same options as hospital nationally to respond to the impact of federal sequester. Therefore, hospitals recommend fully offsetting the impact on hospitals through an increase in rates.

Staff Recommendations

Recommendation 1: The Commission will make no change to hospital rates for Fiscal Year 2013 in response to the sequestration.

Recommendation 2: The Commission will consider total revenue needs of hospitals as part of the update discussions for Fiscal Year 2014, with the shortfall due to sequestration as part of those discussions.

Recommendation 3: The Commission expects to take final action at the June 2013 Commission meeting on a simplified FY2014 update factor that takes into consideration, among other things, factor cost inflation, sequestration, financial condition, and waiver cushion.

Comment Letters

CareFirst BlueCross BlueShield
10455 Mill Run Circle
Owings Mills, MD 21117
www.carefirst.com

March 15,2013

Health Services Cost Review Commission
4201 Patterson Avenue
Baltimore, Maryland 21215

Re: Draft Staff Recommendation – Impact of Sequestration and Options for HSCRC

Dear Commissioners:

CareFirst would like to thank you for this opportunity to comment on the above referenced draft recommendation.

As a result of the federal government failing to enact legislation to reduce the deficit by 2/28/2013, the sequestration efforts will automatically be implemented with the effect of reducing Medicare hospital payments nationally by 2%.

The intent of the sequestration is to reduce federal expenditures nationally by 2%. Therefore, any actions by the HSCRC to increase hospital rates, to cushion the impact of the Medicare payment reduction on Maryland hospitals, will dilute the intent of the federal Sequestration. We believe this action could be perceived unfavorably by CMS and thus could negatively impact the current waiver modernization negotiations. In addition, any such rate increase would both erode the State's position on the current waiver test and disadvantage Maryland under any new waiver test (since Medicare reductions in Maryland would be less than those occurring nationally, resulting in Maryland Hospitals lagging behind national cost targets).

As a result, CareFirst urges the Commission to move forward with Option #3 that will not impact Maryland hospital rates and will allow the full intent of the sequestration to be realized by the federal government.

Sincerely,

John Hampel
Director, Provider Reimbursement, Analytics & Compliance
CareFirst
6731 Columbia Gateway Drive, CG-43
Columbia, MD 21046
410-872-3501 (P)

UNION HOSPITAL

April 12, 2013

John Colmers
Chairman, Health Services Cost Review Commission
3910 Keswick Road
Suite N-2200
Baltimore, MD 21211

Dear Chairman Colmers,

I am writing as a follow-up to the Maryland Hospital Association's (MHA) testimony at the April 10th Health Services Cost Review Commission (HSCRC) meeting, to urge the HSCRC to adopt MHA's recommendations on handling the impact of the federal sequester by fully offsetting the impact on hospitals through a temporary increase in the differential and an increase in rates.

As you know, hospital financial conditions have significantly deteriorated in recent years as a result of low annual payment updates. Combined with the historically low rate update of 0.3 percent for FY2013, margins for the first six months of this year have declined to 0.8 percent — well below the 2.75 percent target margin set by the HSCRC. Requiring hospitals to shoulder any portion of the federal sequester, I believe, would be inconsistent with the HSCRC's statutory mandate to ensure that efficiently and effectively operated hospitals are financially solvent.

Maryland's hospitals should have the same flexibility to respond to the impact of the federal sequester as hospitals in the rest of the country do. In our all-payor system, the only way this can be accomplished is by increasing rates. This action would be consistent with all past efforts to address federal sequesters. In separate actions taken on July 1, 1986, February 9, 1988, and December 1, 1989, the HSCRC voted to offset the impact of federal sequesters, placing the full impact in hospital rates. I would also note that the small negative *and temporary* impact that this policy would have on the current waiver cushion should not preclude the HSCRC from supporting it; even so, this action would still leave the current waiver with a positive cushion.

I urge the HSCRC to act at its May 1st meeting to implement MHA's recommended action, retroactive to April 1, 2013.

Thank you for the opportunity to comment.

Sincerely,

Laurie R. Beyer
Chief Financial Officer, Union Hospital

cc:
Herbert Wong, PhD, Vice Chairman
George H. Bone, MD
Stephen F. Jencks, MD, MPH
Jack C. Keane
Bernadette Loftus, MD
Thomas R. Mullen
Patrick Redmon, PhD

106 Bow Street • Elkton, Maryland 21921 • 410/398-4000 • Fax: 410/392-9486 • TTY: 800-735-2258
www.uhcc.com

JOHNS HOPKINS
MEDICINE

Ronald R. Peterson

President
Johns Hopkins Health System
The Johns Hopkins Hospital

Executive Vice-President
Johns Hopkins Medicine

April 15, 2013

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

Via email: jcolmers@jhmi.edu followed by hard copy

Dear Chairman Colmers,

I am writing on behalf of the Johns Hopkins Health System (JHHS) and its member hospitals, The Johns Hopkins Hospital (JHH), Johns Hopkins Bayview Medical Center (JHBMC), Howard County General Hospital (HCGH), and Suburban Hospital (SH), to comment on the impact of the federal sequester which caused a 2% Medicare payment reduction. Senior leaders at Hopkins have participated with MHA in the development of the MHA position on the sequestration. We strongly support the position MHA recommends on handling the impact of the federal sequester by fully offsetting the impact on hospitals through an increase in the Medicare differential and a rate increase.

As you know, hospital financial conditions have significantly deteriorated in recent years as a result of low annual payment updates. Combined with the historically low rate update of 0.3% for FY 2013, margins for the first six months of this year have declined to 0.8% - well below the 2.75% target margin set by the HSCRC. Requiring hospitals to shoulder any portion of the federal sequester, I believe, would be inconsistent with the HSCRC's statutory mandate to ensure that efficiently and effectively operated hospitals are financially solvent.

In making your decision regarding the Medicare 2% payment reduction due to the Federal Sequester, please consider the following issues directly impacting Maryland hospitals:

- HSCRC Update Factors (UF) have been set significantly below underlying operating cost inflation for 4 years since FY 2009.
- Through FY 2013, HSCRC approved UF's have **underfunded inflation by 5%.**
- **Capital costs** have risen dramatically mostly due to a **normal facility replacement cycle** in the state. Many of the hospitals' major facilities were built in the 1950s - 1960s and have had to be replaced. Replacement facilities provide very little opportunity for volume growth so most of the added capital costs were funded from the existing revenue base.

733 North Broadway, BRB 104, Baltimore, Maryland 21205, 410-955-9540 phone, 410-955-0856 fax, rpeters@jhmi.edu

- There are other **non revenue producing cost requirements** which are essential to the proper management of hospitals such as expanded patient safety programs, health information technology systems and development of core measures. These are necessary programs which may produce cost improvements in the long run but the initial investments are a heavy cost now.
- **Rating Agencies** (Moody's, Fitch, S&P) are watching Maryland's policy decisions. They are concerned that prolonged revenue constraints will cause financial instability and may result in **hospital debt downgrades.**
- **Rating downgrades** will increase the cost of financing and will delay needed capital investments including information technology which is needed to manage healthcare costs and services.

Maryland's hospitals should have the same flexibility to respond to the impact of the federal sequester as do hospitals in the rest of the country. In our all-payor system, the only way this can be accomplished is by increasing rates. This action would be consistent with all past efforts to address federal sequesters. In separate actions taken on July 1, 1986, February 9, 1988, and December 1, 1989, the HSCRC voted to offset the impact of federal sequesters, placing the full impact in hospital rates. I would also note that the small negative and *temporary* impact that this policy would have on the current waiver cushion should not preclude the HSCRC from supporting it; even so, this action would still leave the current waiver with a positive cushion. **I urge the HSCRC to act at its May 1st meeting to implement MHA's recommended action, retroactive to April 1, 2013.**

Thank you for the opportunity to comment.

Sincerely,

Ronald R. Peterson

cc: George H. Bone, MD
Stephen F. Jencks, MD, MPH
Jack C. Keane
Bernadette Loftus, MD
Thomas R. Mullen
Patrick Redmon, PhD
Herbert Wong, PhD, Vice Chairman

UNIVERSITY of MARYLAND
MEDICAL SYSTEM

250 W. Pratt Street
24th Floor
Baltimore, Maryland 21201-6829
www.umms.org

CORPORATE OFFICE

April 15, 2013

John Colmers
Chairman, Health Services Cost Review Commission
3910 Keswick Road
Suite N-2200
Baltimore, MD 21211

Re: **Funding of Federal Sequester**

Dear Chairman Colmers:

On behalf of the University of Maryland Medical System (UMMS) and its member hospitals, I am writing to follow-up on the Maryland Hospital Association's (MHA) testimony at the April 10th Health Services Cost Review Commission (HSCRC) meeting. UMMS includes the following Maryland hospitals:

- University of Maryland Medical Center
- Kernan Orthopaedics and Rehabilitation Hospital
- Maryland General Hospital
- Baltimore Washington Medical Center
- Memorial Hospital at Easton
- Dorchester General Hospital
- Chester River Health System
- Civista Medical Center
- University of Maryland – St. Joseph Medical Center
- Mt. Washington Pediatric Hospital
- Upper Chesapeake Medical Center, and
- Harford Memorial Hospital

UMMS urges the HSCRC to adopt MHA's recommendations on handling the impact of the federal sequester by fully offsetting the impact on hospitals through a temporary increase in the differential and an increase in rates.

As you know, the financial condition of Maryland hospitals has significantly deteriorated in recent years as a result of low annual rate updates. Combined with the historically low rate update of 0.3 percent for fiscal 2013, operating margins for the first six months of this fiscal year have declined to 0.8 percent — well below the 2.75 percent target established by the HSCRC. Requiring hospitals to shoulder any portion of the federal sequester, we believe, would be inconsistent with the HSCRC's statutory mandate to ensure that efficiently and effectively operated hospitals are financially solvent.

In addition, it is important to note that total Maryland hospital patient revenues have only increased by 1.42% for the first eight months of fiscal 2013. This record low increase should result in favorable claims experience and enhanced profitability at commercial insurance carriers. As a result, the health insurance industry is much better positioned than the hospital industry to absorb a sequester related rate increase for the fourth quarter of fiscal 2013.

We also believe that Maryland hospitals should have the same flexibility to respond to the impact of the federal sequester as hospitals in the rest of the United States. In our all-payor system, the only way this can be accomplished is by increasing rates. This action would be consistent with all past efforts to address federal sequesters. In separate actions taken on July 1, 1986, February 9, 1988, and December 1, 1989, the HSCRC voted to offset the impact of federal sequesters by placing the full impact in hospital rates.

I would also note that the small negative *and temporary* impact that this rate increase would have on the current waiver cushion should not preclude the HSCRC from supporting our rate request. And, this temporary rate increase would still leave the current waiver with a positive cushion.

In summary, we urgently request that the HSCRC act at its May 1st meeting to implement MHA's recommended temporary rate increase, retroactive to April 1, 2013.

Thank you for the opportunity to comment on this very important issue.

Sincerely,

Robert A. Chrencik
President and Chief Executive Officer

cc: Herbert Wong, PhD, Vice Chairman
George H. Bone, MD
Stephen F. Jencks, MD, MPH
Jack C. Keane
Bernadette Loftus, MD
Thomas R. Mullen
Patrick Redmon, PhD

MedStar Franklin Square Medical Center

9000 Franklin Square Drive
Baltimore, MD 21237
443-777-7850 PHONE
443-777-7904 FAX
sam.moskowitz@medstar.net
www.medstarfranklin.org

Samuel E. Moskowitz
President,
MedStar Franklin Square Medical Cente
Senior Vice President, MedStar Health

April 15, 2013

Mr. John Colmers
Chairman, Health Services Cost Review Commission
3910 Keswick Road
Suite N-2200
Baltimore, MD 21211

Dear Chairman Colmers,

I am writing to urge the HSCRC to adopt MHA's recommendations on handling the impact of the federal sequester by fully offsetting the impact on hospitals through a temporary increase in the differential and an increase in rates.

One need not tell you that hospital financial conditions have significantly deteriorated in recent years as a result of low annual payment updates and, for some, shrinking demand for hospital care. Combined with the historically low rate update of 0.3 percent for FY2013, margins for the first six months of this year have declined to 0.8 percent — well below the 2.75 percent target margin set by the HSCRC. Requiring hospitals to shoulder any portion of the federal sequester, I believe, would be inconsistent with the HSCRC's statutory mandate to ensure that efficiently and effectively operated hospitals are financially solvent.

Maryland's hospitals should have the same flexibility to respond to the impact of the federal sequester as hospitals in the rest of the country do. In our all-payor system, the only way this can be accomplished is by increasing rates. This action would be consistent with all past efforts to address federal sequesters. In separate actions taken on July 1, 1986, February 9, 1988, and December 1, 1989, the HSCRC voted to offset the impact of federal sequesters, placing the full impact in hospital rates. I would also note that the small negative *and temporary* impact that this policy would have on the current waiver cushion should not preclude the HSCRC from supporting it; even so, this action would still leave the current waiver with a positive cushion.

On behalf of our Board, Medical Staff, I urge the HSCRC to act at its May 1st meeting to implement MHA's recommended action, retroactive to April 1, 2013.

Thank you for the opportunity to comment.

Sincerely,

Samuel E. Moskowitz

cc:
Herbert Wong, PhD, Vice Chairman
George H. Bone, MD
Stephen F. Jencks, MD, MPH
Jack C. Keane
Bernadette Loftus, MD
Thomas R. Mullen
Patrick Redmon, PhD

SAINT AGNES
HEALTHCARE
Bonnie Phipps, President/CEO

April 15, 2013

John Colmers
Chairman, Health Services Cost Review Commission
3910 Keswick Road
Suite N-2200
Baltimore, MD 21211

Dear Chairman Colmers,

Please accept this as a follow-up to the Maryland Hospital Association's (MHA) testimony at the April 10th Health Services Cost Review Commission (HSCRC) meeting, to urge the HSCRC to adopt MHA's recommendations on handling the impact of the federal sequester by fully offsetting the impact on hospitals through a temporary increase in the differential and an increase in rates consistent with past Commission action regarding sequestration in 1986, 1988 and 1989.

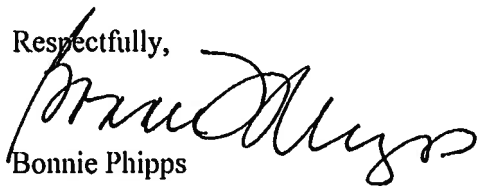
Saint Agnes Hospital would face approximately $640,000 impact in this fiscal year alone if the Commission takes no action. We simply cannot financially survive yet another negative impact in rates. We have seen almost $7 million in this fiscal year alone in cuts, take-backs and changes to already approved programs with signed agreements. We have given one wage increase in three years and have nothing budgeted for FY14 due to the insufficiency of rates. We must cut jobs and services to manage this while others in the healthcare market see stable and even increasing margins.

Maryland hospitals in general have margins below 1% against a target of 2.75%. Requiring hospitals to shoulder any portion of the federal sequester would be inconsistent with the HSCRC's statutory mandate to ensure that efficiently and effectively operated hospitals are financially solvent.

I urge the HSCRC to act at its May 1st meeting to implement MHA's recommended action, retroactive to April 1, 2013. Please help us to protect our communities, our patients and employees and our systems of care.

Thank you for the opportunity to comment.

Respectfully,



Bonnie Phipps

cc:
Herbert Wong, PhD, Vice Chairman
George H. Bone, MD
Stephen F. Jencks, MD, MPH
Jack C. Keane
Bernadette Loftus, MD
Thomas R. Mullen
Patrick Redmon, PhD

EXCEPTIONAL HEALTHCARE. EXCEPTIONAL PEOPLE.

PENINSULA REGIONAL MEDICAL CENTER

April 15, 2013

Mr. John Colmers
Chairman, Health Services Cost Review Commission
3910 Keswick Road
Suite N-2200
Baltimore, MD 21211

Dear Chairman Colmers,

I am writing as a follow-up to the Maryland Hospital Association's (MHA) testimony at the April 10th Health Services Cost Review Commission (HSCRC) meeting, to urge the HSCRC to adopt MHA's recommendations on handling the impact of the federal sequester by fully offsetting the impact on hospitals through a temporary increase in the differential and an increase in rates.

As you know, hospital financial conditions have significantly deteriorated in recent years as a result of low annual payment updates. Combined with the historically low rate update of 0.3 percent for FY2013, margins for the first six months of this year have declined to 0.8 percent — well below the 2.75 percent target margin set by the HSCRC. Requiring hospitals to shoulder any portion of the federal sequester, I believe, would be inconsistent with the HSCRC's statutory mandate to ensure that efficiently and effectively operated hospitals are financially solvent.

Maryland's hospitals should have the same flexibility to respond to the impact of the federal sequester as hospitals in the rest of the country do. In our all-payor system, the only way this can be accomplished is by increasing rates. This action would be consistent with all past efforts to address federal sequesters. In separate actions taken on July 1, 1986, February 9, 1988, and December 1, 1989, the HSCRC voted to offset the impact of federal sequesters, placing the full impact in hospital rates. I would also note that the small negative *and temporary* impact that this policy would have on the current waiver cushion should not preclude the HSCRC from supporting it; even so, this action would still leave the current waiver with a positive cushion.

I urge the HSCRC to act at its May 1st meeting to implement MHA's recommended action, retroactive to April 1, 2013.

Thank you for the opportunity to comment.

Sincerely,

Peggy Naleppa

Dr. Peggy Naleppa, M.S., MBA, FACHE
President/CEO

cc: Herbert Wong, Ph.D., Vice Chairman
George H. Bone, M.D.
Stephen F. Jencks, M.D., MPH
Jack C. Keane
Bernadette Loftus, M.D.
Thomas R. Mullen
Patrick Redmon, Ph.D.

Dennis W. Pullin, FACHE
President, MedStar Harbor Hospital
Senior Vice President, MedStar Health

MedStar Harbor Hospital

April 15, 2013

John Colmers
Chairman, Health Services Cost Review Commission
3910 Keswick Road Suite N-2200
Baltimore, MD 21211

Dear Chairman Colmers,

I am writing as a follow-up to the Maryland Hospital Association's (MHA) testimony at the April 10th Health Services Cost Review Commission (HSCRC) meeting, to urge the HSCRC to adopt MHA's recommendations on handling the impact of the federal sequester by fully offsetting the impact on hospitals through a temporary increase in the differential and an increase in rates.

As you know, hospital financial conditions have significantly deteriorated in recent years as a result of low annual payment updates. Combined with the historically low rate update of 0.3 percent for FY2013, margins for the first six months of this year have declined to 0.8 percent — well below the 2.75 percent target margin set by the HSCRC. Requiring hospitals to shoulder any portion of the federal sequester, I believe, would be inconsistent with the HSCRC's statutory mandate to ensure that efficiently and effectively operated hospitals are financially solvent.

Maryland's hospitals should have the same flexibility to respond to the impact of the federal sequester as hospitals in the rest of the country do. In our all-payor system, the only way this can be accomplished is by increasing rates. This action would be consistent with all past efforts to address federal sequesters. In separate actions taken on July 1, 1986, February 9, 1988, and December 1, 1989, the HSCRC voted to offset the impact of federal sequesters, placing the full impact in hospital rates. I would also note that the small negative *and temporary* impact that this policy would have on the current waiver cushion should not preclude the HSCRC from supporting it; even so, this action would still leave the current waiver with a positive cushion.
I urge the HSCRC to act at its May 1st meeting to implement MHA's recommended action, retroactive to April 1, 2013.

Thank you for the opportunity to comment.

Sincerely,

Dennis W. Pullin, FACHE
President MedStar Harbor Hospital
Sr. Vice President MedStar Health

cc:
Herbert Wong, PhD, Vice Chairman
George H. Bone, MD
Bernadette Loftus, MD
Stephen F. Jencks, MD, MPH
Jack C. Keane
Thomas R. Mullen
Patrick Redmon, PhD

3001 S. Hanover St., Baltimore, MD 21225
410-350-3201 PHONE • 410-354-4440 FAX
dennis.w.pullin@medstar.net

CARROLL
HOSPITAL CENTER

John M. Sernulka
President and CEO

April 15, 2013

John Colmers
Chairman, Health Services Cost Review Commission
3910 Keswick Road
Suite N-2200
Baltimore, MD 21211

Dear Chairman Colmers,

I am writing as a follow-up to the Maryland Hospital Association's (MHA) testimony at the April 10th Health Services Cost Review Commission (HSCRC) meeting, to urge the HSCRC to adopt MHA's recommendations on handling the impact of the federal sequester by fully offsetting the impact on hospitals through a temporary increase in the differential and an increase in rates.

Carroll Hospital Center has partnered with the HSCRC over the past 3 years under our TPR agreement to significantly reduce overutilization and the cost of healthcare. It has been a win/win for residents of Carroll County, payors and employers alike. Achieving this success has clearly had an economic erosion of our financial stability and has heightened our future financial viability as our "NUMBER ONE" enterprise risk. Requiring hospitals to shoulder any portion of the federal sequester, I believe, would severely jeopardize Carroll Hospital Center's ability to ensure that our efficiently and effectively operated hospital remains financially solvent.

Maryland's hospitals should have the same flexibility to respond to the impact of the federal sequester as hospitals in the rest of the country do. In our all-payor system, the only way this can be accomplished is by increasing rates. This action would be consistent with all past efforts to address federal sequesters. In separate actions taken on July 1, 1986, February 9, 1988, and December 1, 1989, the HSCRC voted to offset the impact of federal sequesters, placing the full impact in hospital rates. I would also note that the small negative *and temporary* impact that this policy would have on the current waiver cushion should not preclude the HSCRC from supporting it; even so, this action would still leave the current waiver with a positive cushion.

200 Memorial Avenue
Westminster, MD 21157

410.871.6902
Fax: 410.871.7474

www.CarrollHospitalCenter.org

I urge the HSCRC to act at its May 1st meeting to implement MHA's recommended action, retroactive to April 1, 2013.

Thank you for the opportunity to comment.

Sincerely,

John M. Sernulka
President & CEO

cc: Herbert Wong, PhD, Vice Chairman
George H. Bone, MD
Stephen F. Jencks, MD, MPH
Jack C. Keane
Bernadette Loftus, MD
Thomas R. Mullen
Patrick Redmon, PhD

LIFEBRIDGE
HEALTH

Sinai Hospital
Northwest Hospital
Levindale Hebrew Geriatric Center and Hospital
Courtland Gardens Nursing & Rehabilitation Center

April 16, 2013

John Colmers
Chairman, Health Services Cost Review Commission
3910 Keswick Road
Suite N-2200
Baltimore, MD 21211

Dear Chairman Colmers:

I am writing as a follow-up to the Maryland Hospital Association's (MHA) testimony at the April 10th Health Services Cost Review Commission (HSCRC) meeting, to urge the HSCRC to adopt MHA's recommendations on handling the impact of the federal sequester by fully offsetting the impact on hospitals through a temporary increase in the differential and an increase in rates.

As you know, hospital financial conditions have significantly deteriorated in recent years as a result of low annual payment updates. Combined with the historically low rate update of 0.3 percent for FY2013, margins for the first six months of this year have declined to 0.8 percent — well below the 2.75 percent target margin set by the HSCRC. Requiring hospitals to shoulder any portion of the federal sequester, I believe, would be inconsistent with the HSCRC's statutory mandate to ensure that efficiently and effectively operated hospitals are financially solvent.

Maryland's hospitals should have the same flexibility to respond to the impact of the federal sequester as hospitals in the rest of the country do. In our all-payor system, the only way this can be accomplished is by increasing rates. This action would be consistent with all past efforts to address federal sequesters. In separate actions taken on July 1, 1986, February 9, 1988, and December 1, 1989, the HSCRC voted to offset the impact of federal sequesters, placing the full impact in hospital rates. I would also note that the small negative *and temporary* impact that this policy would have on the current waiver cushion should not preclude the HSCRC from supporting it; even so, this action would still leave the current waiver with a positive cushion. **I urge the HSCRC to act at its May 1st meeting to implement MHA's recommended action, retroactive to April 1, 2013.**

Thank you for the opportunity to comment.

Sincerely,

Neil M. Meltzer

Neil M. Meltzer
President & CEO Designate

c: Herbert Wong, PhD, Vice Chairman
George H. Bone, MD
Stephen F. Jencks, MD, MPH
Jack C. Keane
Bernadette Loftus, MD
Thomas R. Mullen
Patrick Redmon, PhD

MedStar Union
Memorial Hospital

201 E. University Parkway
Baltimore, MD 21218
410-554-2227 PHONE
410-554-2652 FAX
medstarunionmemorial.org

Bradley S. Chambers
President, MedStar Union Memorial Hospital
Senior Vice President, MedStar Health

Administration

April 16, 2013

John Colmers, Chairman
Health Services Cost Review Commission
3910 Keswick Road, Suite N-2200
Baltimore, MD 21211

Dear Chairman Colmers:

I am writing as a follow-up to the Maryland Hospital Association's (MHA) testimony at the April 10th Health Services Cost Review Commission (HSCRC) meeting, to urge the HSCRC to adopt MHA's recommendations on handling the impact of the federal sequester by fully offsetting the impact on hospitals through a temporary increase in the differential and an increase in rates.

As you know, hospital financial conditions have significantly deteriorated in recent years as a result of low annual payment updates. Combined with the historically low rate update of 0.3 percent for FY2013, margins for the first six months of this year have declined to 0.8 percent — well below the 2.75 percent target margin set by the HSCRC. Requiring hospitals to shoulder any portion of the federal sequester, I believe, would be inconsistent with the HSCRC's statutory mandate to ensure that efficiently and effectively operated hospitals are financially solvent.

Maryland's hospitals should have the same flexibility to respond to the impact of the federal sequester as hospitals in the rest of the country do. In our all-payor system, the only way this can be accomplished is by increasing rates. This action would be consistent with all past efforts to address federal sequesters. In separate actions taken on July 1, 1986, February 9, 1988, and December 1, 1989, the HSCRC voted to offset the impact of federal sequesters, placing the full impact in hospital rates. I would also note that the small negative *and temporary* impact that this policy would have on the current waiver cushion should not preclude the HSCRC from supporting it; even so, this action would still leave the current waiver with a positive cushion.

I urge the HSCRC to act at its May 1st meeting to implement MHA's recommended action, retroactive to April 1, 2013.

Thank you for the opportunity to comment.

Sincerely,

Bradley S. Chambers

cc: Herbert Wong, PhD, Vice Chairman
George H. Bone, MD
Stephen F. Jencks, MD, MPH
Jack C. Keane
Bernadette Loftus, MD
Thomas R. Mullen
Patrick Redmon, PhD

MedStar Good Samaritan Hospital

5601 Loch Raven Boulevard
Baltimore, MD 21239-2905
443-444-8000 PHONE
410-323-1794 TTY
443-444-4100 FIND A DOC
goodsam-md.org

April 16, 2013

John Colmers
Chairman, Health Services Cost Review Commission
3910 Keswick Road
Suite N-2200
Baltimore, MD 21211

Dear Chairman Colmers,

I am writing as a follow-up to the Maryland Hospital Association's (MHA) testimony at the April 10th Health Services Cost Review Commission (HSCRC) meeting, to urge the HSCRC to adopt MHA's recommendations on handling the impact of the federal sequester by fully offsetting the impact on hospitals through a temporary increase in the differential and an increase in rates.

As you know, across the state, hospital financial conditions have significantly deteriorated in recent years as a result of low annual payment updates. In fact, with the historically low rate update of 0.3 percent for FY 2013, margins for the first six months of this year have declined to 0.8 percent across the industry. This is a level well below the 2.75 percent target margin set by the HSCRC. In fact, for the first time in recollection MedStar Good Samaritan Hospital (MGSH) is operating at a loss from operations. This is despite MGSH's established track record of efficiency that compares favorably on many metrics to national standards. Our financial condition is a direct result of the decline in revenue that has not kept pace with expense inflation while ensuring quality care and safe operating conditions. As a result of this recent financial downturn, MGSH is already going through significant staff reduction initiatives. Adding the federal sequester to the list of Hospital cuts will only exacerbate an already tenuous situation. In fact, requiring hospitals to shoulder any portion of the federal sequester, I believe, would be inconsistent with the HSCRC's statutory mandate to ensure that efficiently and effectively operated hospitals are financially solvent.

Maryland's hospitals should have the same flexibility to respond to the impact of the federal sequester as hospitals in the rest of the country do. In our all-payor system, the only way this can be accomplished is by increasing rates. This action would be consistent with all past efforts to address federal sequesters. In separate actions taken on July 1, 1986, February 9, 1988, and

December 1, 1989, the HSCRC voted to offset the impact of federal sequesters, placing the full impact in hospital rates. I would also note that the small negative *and temporary* impact that this policy would have on the current waiver cushion should not preclude the HSCRC from supporting it; even so, this action would still leave the current waiver with a positive cushion. **I urge the HSCRC to act at its May 1st meeting to implement MHA's recommended action, retroactive to April 1, 2013.**

Thank you for the opportunity to comment.

Sincerely,

Jeffrey Matton
President, MedStar Good Samaritan Hospital

cc:
Herbert Wong, PhD, Vice Chairman
George H. Bone, MD
Stephen F. Jencks, MD, MPH
Jack C. Keane
Bernadette Loftus, MD
Thomas R. Mullen
Patrick Redmon, PhD

MedStar St. Mary's Hospital

25500 Point Lookout Road
P.O. Box 527
Leonardtown, Maryland 20650
301-475-8981 **PHONE**
medstarstmarys.org

A Century of Caring
1912-2012

100 Years

April 16, 2013

John Colmers
Chairman, Health Services Cost Review Commission
3910 Keswick Road
Suite N-2200
Baltimore, MD 21211

Dear Chairman Colmers:

I am writing as a follow-up to the Maryland Hospital Association's (MHA) testimony at the April 10th Health Services Cost Review Commission (HSCRC) meeting, to urge the HSCRC to adopt MHA's recommendations on handling the impact of the federal sequester by fully offsetting the impact on hospitals through a temporary increase in the differential and an increase in rates.

As you know, hospital financial conditions have significantly deteriorated in recent years as a result of low annual payment updates. Combined with the historically low rate update of 0.3 percent for FY2013, margins for the first six months of this year have declined to 0.8 percent — well below the 2.75 percent target margin set by the HSCRC. Requiring hospitals to shoulder any portion of the federal sequester, I believe, would be inconsistent with the HSCRC's statutory mandate to ensure that efficiently and effectively operated hospitals are financially solvent.

Maryland's hospitals should have the same flexibility to respond to the impact of the federal sequester as hospitals in the rest of the country do. In our all-payor system, the only way this can be accomplished is by increasing rates. This action would be consistent with all past efforts to address federal sequesters. In separate actions taken on July 1, 1986, February 9, 1988, and December 1, 1989, the HSCRC voted to offset the impact of federal sequesters, placing the full impact in hospital rates. I would also note that the small negative *and temporary* impact that this policy would have on the current waiver cushion should not preclude the HSCRC from supporting it; even so, this action would still leave the current waiver with a positive cushion.

I urge the HSCRC to act at its May 1st meeting to implement MHA's recommended action, retroactive to April 1, 2013.

Thank you for the opportunity to comment.

Sincerely,

Christine R. Wray
President

cc: Herbert Wong, PhD, Vice Chairman
George H. Bone, MD
Stephen F. Jencks, MD, MPH
Jack C. Keane
Bernadette Loftus, MD
Thomas R. Mullen
Patrick Redmon, PhD
Carmela Coyle, MHA
Eric Wagner, MedStar Health

MedStar Health

5565 Sterrett Place
5th Floor
Columbia, MD 21044
410-772-6630 PHONE
410-740-1106 FAX
medstarhealth.org

Michael J. Curran
Executive Vice President,
Chief Administrative and
Financial Officer

April 17, 2013

John Colmers
Chairman, Health Services Cost Review Commission
3910 Keswick Road
Suite N-2200
Baltimore, MD 21211

Dear Chairman Colmers:

I am writing as a follow-up to the Maryland Hospital Association's (MHA) testimony at the April 10th Health Services Cost Review Commission (HSCRC) meeting, to urge the HSCRC to adopt MHA's recommendations on handling the impact of the federal sequester by fully offsetting the impact on hospitals through a temporary increase in the differential and an increase in rates.

As you know, hospital financial conditions have significantly deteriorated in recent years as a result of low annual payment updates. Combined with the historically low rate update of 0.3% for FY2013, margins for the first six months of this year have declined to 0.8 percent — well below the 2.75% target margin set by the HSCRC. MedStar Health believes that requiring hospitals to shoulder any portion of the federal sequester would be inconsistent with HSCRC's statutory mandate to ensure that efficiently and effectively operated hospitals are financially solvent.

Maryland's hospitals should have the same flexibility to respond to the impact of the federal sequester as hospitals in the rest of the country do. In our all-payor system, the only way this can be accomplished is by increasing rates. This action would be consistent with all past efforts to address federal sequesters. In separate actions taken on July 1, 1986, February 9, 1988, and December 1, 1989, the HSCRC voted to offset the impact of federal sequesters, placing the full impact in hospital rates. I would also note that the small negative *and temporary* impact that this policy would have on the current waiver cushion should not preclude the HSCRC from supporting it; even so, this action would still leave the current waiver with a positive cushion. **We urge the HSCRC to act at its May 1st meeting to implement MHA's recommended action, retroactive to the date the sequester began on April 1, 2013.**

Thank you for the opportunity to comment.

Sincerely,

Michael J. Curran
Executive Vice President
Chief Administrative and Financial Officer

cc: Herbert Wong, PhD, Vice Chairman
George H. Bone, MD
Stephen F. Jencks, MD, MPH
Jack C. Keane
Bernadette Loftus, MD
Thomas R. Mullen
Patrick Redmon, PhD

MedStar Montgomery
Medical Center

18101 Prince Philip Drive
Olney MD 20832
301-774-8771 PHONE
301-774-8866 FAX
medstarmontgomery.org

Peter W. Monge, FACHE
President

Administration

April 18, 2013

John Colmers
Chairman, Health Services Cost Review Commission
3910 Keswick Road
Suite N-2200
Baltimore, MD 21211

Dear Chairman Colmers,

I am writing as a follow-up to the Maryland Hospital Association's (MHA) testimony at the April 10th Health Services Cost Review Commission (HSCRC) meeting, to urge the HSCRC to adopt MHA's recommendations on handling the impact of the federal sequester by fully offsetting the impact on hospitals through a temporary increase in the differential and an increase in rates.

As you know, hospital financial conditions have significantly deteriorated in recent years as a result of low annual payment updates. Additionally, many of us are reaching a tipping point and cutting jobs and services for FY14. Combined with the historically low rate update of 0.3 percent for FY2013, margins for the first six months of this year have declined to 0.8 percent – well below the 2.75 percent target margin set by the HSCRC. Requiring hospitals to shoulder any portion of the federal sequester, I believe, would be inconsistent with the HSCRC's statutory mandate to ensure that efficiently and effectively operated hospitals are financially solvent.

Maryland's hospitals should have the same flexibility to respond to the impact of the federal sequester as hospitals in the rest of the country do. In our all-payor system, the only way this can be accomplished is by increasing rates. This action would be consistent with all past efforts to address federal sequesters. In separate actions taken on July 1, 1986, February 9, 1988, and December 1, 1989, the HSCRC voted to offset the impact of federal sequesters, placing the full impact in hospital rates. I would also note that the small negative and temporary impact that this policy would have on the current waiver cushion should not preclude the HSCRC from supporting it; even so, this action would still leave the current waiver with a positive cushion.

I urge the HSCRC to act at its May 1st meeting to implement MHA's recommended action, retroactive to April 1, 2013.

Thank you for the opportunity to comment.

Sincerely,

Peter W. Monge, FACHE
President, MedStar Montgomery Medical Center
& Senior Vice President, MedStar Health

cc:
Herbert Wong, PhD, Vice Chairman
George H. Bone, MD
Stephen F. Jencks, MD, MPH
Jack C. Keane
Bernadette Loftus, MD
Thomas R. Mullen
Patrick Redmon, PhD

SINAI HOSPITAL
a LifeBridge Health center

Amy Perry
President

April 18, 2013

Mr. John Colmers, Chairman
Health Services Cost Review Commission
3910 Keswick Road, Suite N-2200
Baltimore, Maryland 21211

Dear Chairman Colmers:

I am writing as a follow-up to the Maryland Hospital Association's (MHA) testimony at the April 10th Health Services Cost Review Commission (HSCRC) meeting, to urge the HSCRC to adopt MHA's recommendations on handling the impact of the federal sequester by fully offsetting the impact on hospitals through a temporary increase in the differential and an increase in rates.

As you know, hospital financial conditions have significantly deteriorated in recent years as a result of low annual payment updates. Combined with the historically low rate update of 0.3 percent for FY2013, margins for the first six months of this year have declined to 0.8 percent — well below the 2.75 percent target margin set by the HSCRC. Requiring hospitals to shoulder any portion of the federal sequester, I believe, would be inconsistent with the HSCRC's statutory mandate to ensure that efficiently and effectively operated hospitals are financially solvent.

Maryland's hospitals should have the same flexibility to respond to the impact of the federal sequester as hospitals in the rest of the country do. In our all-payor system, the only way this can be accomplished is by increasing rates. This action would be consistent with all past efforts to address federal sequesters. In separate actions taken on July 1, 1986, February 9, 1988, and December 1, 1989, the HSCRC voted to offset the impact of federal sequesters, placing the full impact in hospital rates. I would also note that the small negative *and temporary* impact that this policy would have on the current waiver cushion should not preclude the HSCRC from supporting it; even so, this action would still leave the current waiver with a positive cushion. **I urge the HSCRC to act at its May 1st meeting to implement MHA's recommended action, retroactive to April 1, 2013.**

Thank you for the opportunity to comment.

Sincerely,

Amy Perry
President-Sinai Hospital of Baltimore
Executive Vice President-LifeBridge Health

CC: HSCRC Commissioners

HOLY CROSS HEALTH

1500 Forest Glen Road
Silver Spring, MD
20910-1484
(301) 754-7000
www.holycrosshealth.org

April 22, 2013

Mr. John M. Colmers
Chairman
Health Services Cost Review Commission
3910 Keswick Road
Baltimore, Maryland 21211

Dear Chairman Colmers,

I am writing to you as follow-up on the Maryland Hospital Association's (MHA) testimony presented at the April 10th meeting of the Health Services Cost Review Commission (HSCRC). This testimony urged the adoption of MHA's recommendation to offset the full impact of the federal sequester through a temporary increase in the differential and an increase in rates and I support this recommendation.

As you know, hospital financial conditions have significantly deteriorated in recent years due to low annual payment updates despite hospitals' efforts to increase efficiencies and overall productivity. With the low update granted in FY 2013 of 0.3 per cent, we have seen further deterioration of hospital margins for the first six months of the year to 0.8 percent which is well below the 2.75 percent target established by the HSCRC. We believe the lack of relief on the federal sequester compounds the impact of this historically low update and, in fact, turns it negative. In addition, requiring hospitals to shoulder the burden of this sequester would be inconsistent with the HSCRC statutory mandate to ensure that efficiently and effectively managed hospitals are financially solvent.

As an industry, we are making strong efforts to operate within a constrained resource environment, even as we are faced with balancing community needs, particularly access for the uninsured and underinsured population, with the essential investments necessary to meet the future needs of our growing community. For example, Holy Cross Hospital has been committed to providing access for the uninsured and underinsured as evidenced by the steady growth in its annual charity care commitment from $12.4 million in fiscal 2009 to $23.7 million in fiscal 2012 which we accomplish despite historically low payment updates. We are also trying to invest in preparing for the redesign of our care delivery system in anticipation of population based health management. It is extremely difficult to make these critical investments and support the new operating model required for population health while maintaining our commitment to our staff which we take very seriously. I urge the HSCRC to act at its May 1st meeting to implement the MHA's recommended action retroactive to April 1, 2013.

Thank you in advance for your thoughtful consideration.

Sincerely,

Anne D. Gillis
Chief Financial Officer

Cc: Herbert Wong, PhD, Vice Chairman
George H. Bone, MD
Stephen F. Jencks, MD MPH
Jack C. Keane
Bernadette Loftus, MD
Thomas R. Mullen
Patrick Redmon, PhD

Adventist HealthCare

820 W. Diamond Avenue, Suite 600
Gaithersburg, MD 20878
Office: 301-315-3030
Fax: 301-315-3000

April 19, 2013

John Colmers
Chairman, Health Services Cost Review Commission
3910 Keswick Road
Suite N-2200
Baltimore, MD 21211

Dear Chairman Colmers,

I am writing on behalf of Adventist Healthcare including Shady Grove Adventist Hospital, Washington Adventist Hospital and Adventist Behavioral Health as a follow-up to the Maryland Hospital Association's (MHA) testimony at the April 10th Health Services Cost Review Commission (HSCRC) meeting. We would like to urge the HSCRC to adopt MHA's recommendations on handling the impact of the federal sequester by fully offsetting the impact on hospitals through a temporary increase in the differential and an increase in rates.

As you know, hospital financial conditions have significantly deteriorated in recent years as a result of low annual payment updates. Combined with the historically low rate update of 0.3 percent for FY2013, margins for the first six months of this rate year have declined to an average of 0.8 percent — well below the 2.75 percent target margin set by the HSCRC. We believe that requiring hospitals to shoulder any portion of the federal sequester would be inconsistent with the HSCRC's statutory mandate to ensure that efficiently and effectively operated hospitals are financially solvent.

Maryland's hospitals should have the same flexibility to respond to the impact of the federal sequester as hospitals in the rest of the country do. In our all-payor system, the only way this can be accomplished is by increasing rates. This action would be consistent with all past efforts to address federal sequesters. In separate actions taken on July 1, 1986, February 9, 1988, and December 1, 1989, the HSCRC voted to offset the impact of federal sequesters, placing the full impact in hospital rates. We would also note that the small negative *and temporary* impact that this policy would have on the current waiver cushion should not preclude the HSCRC from supporting it; even so, this action would still leave the current waiver with a positive cushion.

We urge the HSCRC to act at its May 1st meeting to implement MHA's recommended action, retroactive to April 1, 2013.

Thank you for the opportunity to comment.

Sincerely,

James G. Lee
Executive Vice President and Chief Financial Officer
Adventist Healthcare

cc:
Herbert Wong, PhD, Vice Chairman
George H. Bone, MD
Stephen F. Jencks, MD, MPH
Jack C. Keane
Bernadette Loftus, MD
Thomas R. Mullen
Patrick Redmon, PhD

NEXUS HEALTH
Carolyn Boone Lewis Health Care Center (CBL)
Fort Washington Medical Center (FWMC)

April 22, 2013

John Colmers
Chairman, Health Services Cost Review Commission
3910 Keswick Road
Suite N-2200
Baltimore, MD 21211

Dear Chairman Colmers:

I am writing as a follow-up to the Maryland Hospital Association's (MHA) testimony at the April 10th Health Services Cost Review Commission (HSCRC) meeting, to urge the HSCRC to adopt MHA's recommendations on handling the impact of the federal sequester by fully offsetting the impact on hospitals through a temporary increase in the differential and an increase in rates.

As you know, hospital financial conditions have significantly deteriorated in recent years as a result of low annual payment updates. Combined with the historically low rate update of 0.3 percent for FY2013, margins for the first six months of this year have declined to 0.8 percent — well below the 2.75 percent target margin set by the HSCRC. Requiring hospitals to shoulder any portion of the federal sequester, I believe, would be inconsistent with the HSCRC's statutory mandate to ensure that efficiently and effectively operated hospitals are financially solvent.

Maryland's hospitals should have the same flexibility to respond to the impact of the federal sequester as hospitals in the rest of the country do. In our all-payor system, the only way this can be accomplished is by increasing rates. This action would be consistent with all past efforts to address federal sequesters. In separate actions taken on July 1, 1986, February 9, 1988, and December 1, 1989, the HSCRC voted to offset the impact of federal sequesters, placing the full impact in hospital rates. I would also note that the small negative *and temporary* impact that this policy would have on the current waiver cushion should not preclude the HSCRC from supporting it; even so, this action would still leave the current waiver with a positive cushion.

I urge the HSCRC to act at its May 1st meeting to implement MHA's recommended action, retroactive to April 1, 2013.

Thank you for the opportunity to comment.

Sincerely,

Verna S. Meacham

Verna S. Meacham
President & CEO
Nexus Health, Inc., *parent company of Fort Washington Medical Center*

cc:
Herbert Wong, PhD, Vice Chairman
George H. Bone, MD
Stephen F. Jencks, MD, MPH
Jack C. Keane
Bernadette Loftus, MD
Thomas R. Mullen
Patrick Redmon, PhD

MedStar Southern Maryland
Hospital Center

7503 Surratts Rd.
Clinton, MD 20735
301-868-8000 PHONE
medstarsouthernmaryland.org

April 22, 2013

Patrick Redmon, PhD
Health Services Cost Review Commission
41060 Patterson Ave.
Baltimore, MD 21211

Dear Dr. Redmon,

I am writing as a follow-up to the Maryland Hospital Association's (MHA) testimony at the April 10th Health Services Cost Review Commission (HSCRC) meeting, to urge the HSCRC to adopt MHA's recommendations on handling the impact of the federal sequester by fully offsetting the impact on hospitals through a temporary increase in the differential and an increase in rates.

As you know, hospital financial conditions have significantly deteriorated in recent years as a result of low annual payment updates. Combined with the historically low rate update of 0.3 percent for FY2013, margins for the first six months of this year have declined to 0.8 percent — well below the 2.75 percent target margin set by the HSCRC. Requiring hospitals to shoulder any portion of the federal sequester, I believe, would be inconsistent with the HSCRC's statutory mandate to ensure that efficiently and effectively operated hospitals are financially solvent.

Maryland's hospitals should have the same flexibility to respond to the impact of the federal sequester as hospitals in the rest of the country do. In our all-payor system, the only way this can be accomplished is by increasing rates. This action would be consistent with all past efforts to address federal sequesters. In separate actions taken on July 1, 1986, February 9, 1988, and December 1, 1989, the HSCRC voted to offset the impact of federal sequesters, placing the full impact in hospital rates. I would also note that the small negative *and temporary* impact that this policy would have on the current waiver cushion should not preclude the HSCRC from supporting it; even so, this action would still leave the current waiver with a positive cushion.
I urge the HSCRC to act at its May 1st meeting to implement MHA's recommended action, retroactive to April 1, 2013.

Thank you for the opportunity to comment.

Sincerely,

Michael J. Chiaramonte, MBA
President, MedStar Southern Maryland Hospital Center
Vice President, MedStar Health

cc:
Herbert Wong, PhD, Vice Chairman
George H. Bone, MD
Stephen F. Jencks, MD, MPH
Jack C. Keane
Bernadette Loftus, MD
Thomas Mullen, PhD

Chet Burrell
President and Chief Executive Officer

CareFirst BlueCross BlueShield
1501 S. Clinton Street, 17th Floor
Baltimore, MD 21224-5744
Tel: 410-605-2558
Fax: 410-781-7606
chet.burrell@carefirst.com

CareFirst BlueCross BlueShield

April 25, 2013

Health Services Cost Review Commission
4201 Patterson Avenue
Baltimore, Maryland 21215

Re: Draft Recommendation on Modifications to the Admission-Readmission Revenue (ARR) Methodology and the HSCRC Response to the Federal Sequestration Legislation

Dear Commissioners:

CareFirst is providing the following comments on the draft ARR policy (including the proposed changes in the outlier methodology) and on the question of how the HSCRC should respond to the Medicare rate cut that has resulted from the federal sequestration legislation.

We believe that the HSCRC's actions on these policy issues will substantially impact its ability to hold hospital payment increases within the constraints imposed by the existing per case Medicare waiver test and the more challenging per capita limitations that have been proposed in the waiver application to the Center for Medicare and Medicaid Innovations (CMMI).

The goals and objectives that are established in the application cannot be achieved without strong leadership by the HSCRC. We urge the HSCRC to begin the difficult task of starting the process of achieving the needed changes by acting on the ARR, outlier and sequestration policies.

A. The Draft ARR Recommendations

Maryland has one of the highest hospital readmission rates in the U.S. Its Medicare readmission rate has been found in recent years to be the highest of all states and the highest in the U.S. outside of the District of Columbia. While the majority of readmissions are unavoidable, many readmissions are preventable. These readmissions have the effect of reducing patient satisfaction, raising patient risks and increasing total health system costs. The reduction of unnecessary readmissions is a national priority that has been endorsed by MedPAC and implemented by CMS for the Medicare program outside of Maryland.

Currently, the HSCRC allows the thirty-one (31) hospitals that have elected to participate in its ARR program to keep all of the revenue associated with their prior level of readmissions by bundling both the charges associated with the initial admission and the readmissions into an overall "Charge Per Episode" (CPE) that is established on an APR DRG-specific basis for each hospital. This policy has two undesirable effects: first, it locks in the prior level of payments despite the fact that some portion of the prior revenue associated with readmissions was tied to preventable readmissions; and, second, it undermines Maryland's position on the current per case waiver test by promoting reductions in readmissions without any reduction in payments. The result of reducing the denominator (i.e., admissions) while maintaining the numerator (i.e., payments) is a higher payment per case and a lower Medicare waiver margin under the existing per case test.

The Accountable Care Act (ACA) requires Maryland to establish a readmissions reduction program that will "meet or exceed" the financial savings that would be generated by the federal policy that applies to Medicare hospital payments outside of this state. The federal readmissions program is narrower than the current HSCRC program (it applies to only three DRGs) but it is designed to generate savings equal to 0.3% of total Medicare inpatient payments to the hospitals that are covered by it. Therefore, the HSCRC must modify its existing ARR policy to yield savings equal to or in excess of those that would be produced by the federal program in order to maintain its exemption from the federal readmissions policy.

The HSCRC staff has proposed to revise the ARR policy in three ways: first, to move the existing voluntary ARR program to a compulsory standard policy for all hospitals by terminating the existing agreements; second, to impose a targeted level of readmissions savings on hospitals on a pro rata basis with adjustments to screen out planned (i.e., medically appropriate) readmissions and to exempt the Total Patient Revenue (TPR) hospitals from these savings requirements; and, third, to implement changes in the methodology that is used by the HSCRC to define "outlier" cases and associated charges.

We believe the proposed changes in the outlier methodology should be separated from the proposed ARR policy changes notwithstanding the fact that they were included by the HSCRC staff as part of the draft ARR recommendations that were presented on April 10, 2013. Given their inclusion in the draft ARR recommendations, we feel compelled to address them in these comments.

While the proposed cancellation of the existing voluntary ARR agreements raises concerns about the confidence the hospitals will have in the future regarding voluntary arrangements, we recognize the need to correct the inherent deficiencies of the existing ARR policy and to respond to the ACA's requirements. The ACA has imposed the readmission reduction requirement on the HSCRC. In addition, the existing ARR policy that is reflected in the voluntary agreements is flawed and demands changes for the reasons cited above. We will defer to the HSCRC's legal counsel regarding the legality of the proposed cancellation of the existing agreements but we certainly endorse the need for a broad revamping of the existing policy.

In general, we believe that the HSCRC staff's proposed use of a pro rata ARR methodology that will impose, at the start of the rate year, a predetermined level of readmissions savings in relation to the performance of the individual hospitals is appropriate. The proposed approach, which would compare each hospital's readmissions to the statewide average level of readmissions by

APR SOI cell (i.e., by type of case adjusted by case mix and severity level) is meritorious. The adjustment for "planned" readmissions is appropriate and the targeted savings approach gives a strong financial incentive to reduce unnecessary readmissions to the degree possible in order to offset the readmissions penalty in FY 2014 and in subsequent years. We believe that the penalties imposed should be adjusted in future years if the hospitals achieve levels of readmissions that approach appropriate levels.

In addition, we believe the HSCRC should develop a practical method to take into account the effects of differences in socioeconomic status and/or other factors (such as the presence of a secondary diagnosis of mental illness or substance abuse) that are outside of hospital control that significantly affect the level of preventable readmissions. We also believe that the HSCRC should move expeditiously to develop a unique patient identifier that will allow it to track readmissions across hospitals. It is especially imperative for the HSCRC to address the problems that continue to stymie the implementation of a unique patient ID in preparation for the per capita test that would accompany the new waiver arrangement. Finally, it is our understanding that the net level of admissions that flow into Maryland from other states (or out from Maryland to other states) has been relatively stable over time but the HSCRC will need to make efforts to track these flows more carefully under a per capita waiver system.

In its April 10, 2013 draft ARR recommendation, the HSCRC staff discussed but did not take a position on the matter of whether the targeted readmissions savings should be set at 0.3% or 0.5%. We strongly advocate the use of the 0.5% savings target because the level of Medicare readmissions in Maryland is high relative to the nation. We know from the experience of our own "Patient Centered Medical Home" (PCMH) program—which has now completed its second full year of operation throughout Maryland, the District of Columbia and Northern Virginia—that appropriate financial incentives can significantly reduce the level of inappropriate readmissions. Given these observations, we strongly urge the HSCRC to adopt a targeted savings level of 0.5% in the revised ARR policy.

B. Outlier Methodology

As noted above, the HSCRC staff included proposed changes to the existing outlier methodology as part of its proposed changes to the ARR policy. We believe that these recommendations are severable from the rest of the ARR policy recommendation; that the bases for and techniques and formulas used in the outlier proposal(s) that are being made by the staff need to be more clearly articulated; and that additional data and analyses are needed before the Commissioners can judge the merits or demerits of the proposed outlier methodology changes in an informed manner.

In particular, we believe that the proposed use of a statewide outlier threshold (rather than a hospital-specific threshold) that was included in the April 10 staff recommendation has the undesirable effect of shifting outlier protection away from hospitals with relatively low charges to hospitals with relatively high charges. This effect is readily confirmed by the fact that Figure 9 in the HSCRC staff's draft ARR recommendation would reduce the level of outlier charges by 29% on a statewide basis; virtually maintain the level of outlier charges at Johns Hopkins Hospital; and reduce outlier charges overall (i.e., for all hospitals except Johns Hopkins) by approximately 40%. We do not believe this shift of outlier protection to a single, large hospital is warranted on any logical or factual basis. The staff recommendation did not provide a rationale for it other than the desire to simplify the administration of the outlier policy. We do not believe that administrative simplification is a sufficient basis for a methodological change that would have these highly skewed policy and revenue impacts.

In addition to causing a major change in the baseline distribution of outlier revenue across hospitals, the HSCRC staff's outlier proposal would provide hospitals with additional opportunities to restructure their charges to generate much higher outlier charges in future years. These charges would be passed through as additional revenue and the hospitals could simultaneously offset their higher charges for outlier cases by lowering their charges for non-outlier cases. The effect of these charge adjustments would be to reduce the charges for the non-outlier cases and thereby create undercharges relative to the approved amounts for these cases. The hospitals would be permitted to raise their charges under the Charge Per Case (CPC) constraint that would apply to these cases. In combination, these types of actions would raise payments per case and hurt Maryland's position under the current per case test and under the proposed per capita test. The opportunities to generate additional revenue would be skewed in the direction of the high charge hospitals if a statewide outlier threshold is used because their cases would be more likely to surpass the outlier threshold.

We believe that the HSCRC could substantially fix the problems that we have identified in the proposed outlier policy, and achieve a substantial level of administrative simplification, by establishing a hospital-specific outlier threshold for high charge level hospitals; by using a statewide outlier threshold for the other hospitals; and by eliminating, the $100,000 "dead zone" limitation which has the obvious and undesirable effect of artificially identifying more cases as outliers at the relatively high charge hospitals.

Finally, recent Maryland legislation requires the HSCRC to obtain stakeholder input prior to the adoption of the policy and methodology changes under a new waiver arrangement. We believe the HSCRC should, in the course of this review process, invite and facilitate broad public discussion of all important issues. In regard to the outlier policy, this review process should do the following:

(1) address the question of whether outliers increase or decrease the financial incentives to hospitals to improve care, with special attention to the relative need (if any) for outlier protection in large, medium and small hospitals;

(2) examine the relative levels of adverse events (e.g., falls, nosocomial infections, etc.) across hospitals and the impacts of differing levels of such events on outliers at the particular hospitals; and

(3) consider the merits of imposing hospital-specific rate adjustments (both positive and negative) to drive reductions in the level of adverse events and to reward unusually good performance in this area.

C. The HSCRC Response to the Federal Sequestration Legislation

The federal Budget Control Act of 2011 included provisions that imposed an automatic sequestration (i.e., reduction) in federal payments for various federal programs, including Medicare, as a result of the failure of Congress to achieve targeted deficit reductions. The 2.0% payment reductions that have been imposed by sequestration apply to Medicare hospital payments in Maryland and elsewhere throughout the U.S.

The Maryland Hospital Association (MHA) and individual hospitals have argued that the HSCRC should act immediately to raise rates to fully exempt the hospitals from the impact of the sequestration legislation. The hospitals have argued for relief on three bases: (1) they have cited past actions by the HSCRC that fully offset the effects of federal sequestrations as relevant precedents; (2) they have described the declines they have recently experienced in operating profits; and (3) they have argued that it would be unfair to impose on them the payment reductions that would flow from sequestration when hospitals in other states have the opportunity to shift such payment reductions to other payers (i.e., private sector payers). The MHA and the hospitals have also argued that the HSCRC could raise rates now to offset the sequestration cuts on a temporary basis and re-visit the issue of whether or not to impose the sequester reductions (fully or partially) during the determination of the update factor for RY 2014 in its entirety or for the July through December 2013 "stub" period.

In their draft recommendations of April 10, 2013, the HSCRC staff advised the HSCRC that it should not take any action at this time to offset the effects of sequestration and should consider these effects in the determination of the update factor for all or part of RY 2014. We strongly endorse this HSCRC staff recommendation for the reasons we present below.

First, the HSCRC's past actions to fully pass through the effects of previous sequestrations took place during the mid and late 1980s when the waiver margin was substantially more robust than it is today. The margin was relatively high at that time because the HSCRC did an outstanding job of controlling overall and Medicare cost increases during its early years through 1992. Since 1992, the increases in hospital costs per admission in Maryland have substantially exceeded the national average rate of growth. Different circumstances require different actions. We do not believe that the cited historical actions establish precedents that should be followed at this time given the highly precarious waiver margin that is projected for June 2014.

Second, it is true that operating margins have recently declined but profits on regulated business are much higher than overall operating profits. The hospitals have identified physician subsidies as the primary cause of the difference between operating profits and regulated profits. The legality of the HSCRC's incorporation of the effects of physician subsidies on profits as a basis for higher rates is an unsettled and highly controversial proposition. It would certainly be inappropriate for the HSCRC to relieve the hospitals of the effects of sequestration without examining the levels of physician subsidies, the types of subsidies and their effects on overall hospital costs. This information is typically not disclosed by the hospitals.

Third, the ability of hospitals outside of Maryland to shift the effects of the sequestration payment cut of 2.0% is extremely limited in the short term because they cannot shift them to Medicaid; they cannot shift them, to any significant degree, to the large private health plans, which account for the bulk of private sector payments, because these plans pay for hospital care mostly in the form of fixed rates that cannot be raised prior to the termination of existing contracts; and they cannot shift them to the portion of patients who do not pay for their care. Thus, the argument that hospitals elsewhere can shift the effects of the sequester cuts is wholly unpersuasive as a basis for adjusting rates in Maryland in the remainder of FY 2013. Moreover, the ability of hospitals outside of Maryland to shift the sequestration cuts to the private sector in future years (i.e., beyond the short term) is also limited because many private health plans

have multi-year contracts with fixed rates and the widespread adoption of "high deductible health plans" (HDHPs) by small and large employers frequently causes bad debt levels to rise when hospitals increase their rates. As the HSCRC staff has suggested, the impact of the sequester cuts in FY 2014 can be considered as one of the myriad factors that should be discussed in the determination of the update factor for FY 2014.

Finally, the State of Maryland is currently involved in the extremely important task of attempting to negotiate a revised waiver arrangement for FY 2014. The HSCRC's existing one day stay policy (which encourages hospitals to reduce one day stays without imposing any revenue reductions) and its existing ARR policy (which encourages reductions in readmissions without any reductions in revenue) have the respective effects of thwarting the federal RAC policy (which takes revenue away from hospitals outside Maryland for excessive one day stays) and the federal readmissions reduction program (which imposes, on average, a 0.3% reduction in hospital inpatient payments). The willingness of CMMI to grant a new waiver to Maryland may be influenced by the extent to which Maryland demonstrates its determination to control Medicare and overall hospital payments.

Specifically, if Maryland overrides any portion of the sequestration savings that Medicare would obtain in the absence of the waiver, and shifts Medicare sequester cuts to the private sector, CMMI may question the credibility of Maryland's commitment to the "all payer" system that exists today and is proposed to continue under the waiver application.

D. Conclusion

In summary, we partially support the HSCRC staff's recommendation, dated April 10, 2013, regarding the ARR policy; and we wholly endorse the HSCRC staff's recommendation that the HSCRC should not adjust rates during FY 2013 in response to the federal sequestration cuts and that it should consider the effects of these cuts, among the many other relevant factors that merit attention, in the determination of the update factor for FY 2014.

Thank you for the opportunity to submit our comments on the proposed ARR and sequestration actions.

Sincerely,

Chet Burrell
President and CEO

Final Recommendation on a Shared Savings Policy

Health Services Cost Review Commission

4160 Patterson Avenue Baltimore, MD 21215

(410) 764-2605

May 1, 2013

This represents the recommendation as approved by the Commission on May 1, 2013.

Introduction

This recommendation proposes that the Commission implement a shared savings policy.

Past Commission Actions

HSCRC staff reported to the Commission on inclusion of a shared savings policy in conjunction with potential FY 2014 modifications to the ARR program at the November 7, 2012 and February 6, 2013 Commission meetings. As a draft recommendation at the April 10, 2013 meeting, Commission staff recommended the development of a shared saving methodology as a component of ARR. Based on public input, HSCRC staff has modified the draft recommendation to implement a shared savings policy based on readmissions, but outside of the ARR program structure.

Stakeholder Process

HSCRC staff engaged industry representatives to discuss shared savings as a component of ARR. HSCRC staff held our first workgroup on January 24, 2013 with hospital representatives, followed by a payer discussion on January 31. Most recently, HSCRC staff met with representatives from both hospitals and payers on March 14, followed by a meeting with the Maryland Hospital Association (MHA) on March 21, 2013. Subsequent to presenting the draft recommendation, HSCRC staff discussed recommendation modifications with a number of hospital representatives. We have included a letter from MHA in Appendix A.

Background

CMS Readmissions Program and Shared Savings

As noted in previous reports to the Commission, as of federal fiscal year 2013, Section 3025 of the Patient Protection and Affordable Care Act (H.R. 3590) requires the Secretary of Health and Human Services to reduce payments to hospitals relative to excess readmissions as a means to reducing Medicare readmissions nationally. Medicare requires Inpatient Prospective Payment System (IPPS) hospitals outside of Maryland to engage in Medicare's Hospital Readmissions Reduction program.

The Secretary is authorized to exempt Maryland hospitals from the Medicare Readmissions Reduction Program if Maryland submits an annual report describing how a similar program in the State achieves or surpasses the measured results in terms of patient health outcomes and cost savings under the Medicare program.

While both Medicare's and the HSCRC's readmissions reductions programs aim to reduce readmissions, the two programs' structures differ. ARR is broader than Medicare's program, applying of all-cause readmissions for all APR-DRGs. Medicare's program measures only heart attack, heart failure, and pneumonia. However, the HSCRC's ARR program tracks readmissions only to the facility of the index admission (an eligible admission to an acute hospital), focusing on intra-hospital (and in some cases intra-system) readmission. Currently, there is no identifier in the HSCRC data that tracks patients across facilities; therefore, readmissions across facilities cannot be identified.[1] Finally, the HSCRC program is constructed in a manner that converts existing admissions and readmissions into CPE approved revenue

[1] HSCRC and CRISP staff will report on the status of CRISP to HSCRC dataset matching at the June 2013 Commission meeting.

on a revenue neutral basis, allowing hospitals to keep the profit when readmissions are eliminated. Likewise, hospitals are at risk for increased readmissions on a case mix adjusted basis. In contrast, Medicare penalizes hospitals for high readmission rates, resulting in an overall system payment reduction of 0.3 percent of inpatient revenue in FY 2013 (CMS scales each hospital's DRG payments between 0 and 1 percent, for a national aggregate reduction of 0.3 percent) . Figure 1 reviews the status of Maryland hospitals compared to all US hospitals using CMS' FY2013 IPPS Final Rule: Hospital Readmissions Reduction Program-Supplemental Data (Revised March 2013).

Figure 1: Maryland Hospitals Ranked By Excess Readmissions in CMS' Hospital Readmissions Reduction Program*

National Quartiles: Hospital Ranked From Least to Most Excess Readmissions	Excess Readmissions Due To:		
	Pneumonia	Heart Failure	Heart Attack
Quartile 1 (Least Excess Readmissions)	4 (9%)	4 (9%)	2 (5%)
Quartile 2	4 (9%)	6 (14%)	7 (19%)
Quartile 3	7 (16%)	14 (32%)	10 (27%)
Quartile 4 (Most Excess Readmissions)	**29 (66%)**	**20 (45%)**	**18 (49%)**
Total hospitals included in analysis	3,123	3,110	2,262

Source: HSCRC analysis of CMS Readmission data, April 2013.
Note: Based on CMS data from July 1, 2008 to June 30, 2011. Some Maryland hospital did not have enough cases for CMS to calculate excess readmission figures (pneumonia= 1 hospital, health failure=1 hospital, heart attack=8 hospitals).

As illustrated in Figure 1, the majority of Maryland hospitals were ranked below the national average for Medicare's Hospital Readmission indicators, and many were in the lowest 25 percent. Four Maryland hospitals were ranked in the worst 100 hospitals in the nation for each of the three indicators. For pneumonia readmissions, one-fifth of Maryland hospitals (n=9) were ranked among the worst 200 hospitals in the nation for excess readmissions.

Medicare staff indicated that Maryland's ARR program may not meet the ACA "meet or exceed" requirement for financial savings to Medicare due to the lack of explicit savings. In the federal fiscal year 2013 final IPPS rule, CMS agreed to take a multi-year look at the existing program in Maryland for federal fiscal year 2013, while providing strong indication that HSCRC must develop an explicit policy to demonstrate Medicare savings based on hospital readmissions to gain exemption in federal fiscal year 2014.[2]

ARR Year 1 and Year 2 Status

From FY2011 to FY2012 (ARR Year 1 is FY2012), Maryland hospitals reduced both the admissions and readmissions as seen in Figure 2. From FY2011 to FY2012, readmissions decreased by 6.73 percent while

[2] Department of Health and Human Services, Centers for Medicare & Medicaid Services, 42 CFR Parts 412, 413, 424, and 476, [CMS-1588-F], RIN 0938-AR12. Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Fiscal Year 2013 Rates; Hospitals' Resident Caps for Graduate Medical Education Payment Purposes; Quality Reporting Requirements for Specific Providers and for Ambulatory Surgical Centers. Final rule.

admissions decreased by 3.49 percent. In contrast, observations increased over the same time period by 45.54 percent. While ED visits increased by 4.5 percent from FY2011 to FY2012, ED visits occurring within 30 days of an inpatient stay decreased by 1.55 percent. The figure also includes the same indicators using hospital charges. Charges are not price leveled year to year.

Figure 2: Readmission and Related Utilization Trends: All-Cause, 30-Day Intra Hospital Readmissions By Counts and Charges

	Fiscal Year			Percent Difference		
Indicator	**FY2010**	**FY2011**	**FY2012**	**FY2010-11**	**FY2011-12**	**Difference**
Total Readmissions	74,474	70,766	65,999	-4.98%	-6.74%	-1.76%
Total Charges for Readmissions	$1,037,799,701	$1,047,939,068	$1,031,053,591	0.98%	-1.61%	-2.59%
Average Weight for Readmissions*	1.10	1.11	1.13	0.91%	1.80%	0.89%
Total Admissions	759,991	729,961	704,459	-3.95%	-3.49%	0.46%
Total Charges	$8,908,292,615	$9,096,083,627	$9,267,436,263	2.11%	1.88%	-0.22%
Average Weight	0.97	0.98	0.99	1.03%	1.02%	-0.01%
Readmissions as % of Total Admissions	9.80%	9.69%	9.37%	-1.07%	-3.36%	-2.29%
Readmission Charges as % of Total Charges	11.65%	11.52%	11.13%	-1.11%	-3.43%	-2.32%
0-1 Day Stay Readmissions	11,925	10,827	9,268	-9.21%	-14.40%	-5.19%
Charges for 0-1 Day Stay Readmissions	$ 54,285,434	$49,865,299	$45,016,700	-8.14%	-9.72%	-1.58%
Average Weight for 0-1 Day Stay Readmissions	0.80	0.79	0.80	-1.25%	1.27%	2.52%
0-1 Day Stay Admissions	153,914	132,657	118,158	-13.81%	-10.93%	2.88%
Charges for 0-1 Day Stay Admissions	$829,551,838	$751,930,937	$721,675,864	-9.36%	-4.02%	5.33%
Average Weight for 0-1 Day Admissions	0.78	0.79	0.80	1.28%	1.27%	-0.02%
0-1 Day Stays as % of Total Admissions	20.25%	18.17%	16.77%	-10.27%	-7.71%	2.56%
0-1 Day Stay Readmissions as % of Total Readmissions	16.01%	15.30%	14.04%	-4.45%	-8.22%	-3.77%
0-1 Day Stay Charges as % of Total Charges	9.31%	8.27%	7.79%	-11.23%	-5.80%	5.43%
Total Number of Observations	3,437	74,685	108,695	**	45.54%	
Total Charges for Observations	$12,813,194	$252,720,990	$435,402,509	**	72.29%	
Total Number of Observations within 30 Day of Inpatient Stay	208	5,217	7,520	**	44.14%	
Total Charges for Observations within 30 Day of Inpatient Stay	$1,511,118	$51,966,306	$81,088,118		56.04%	
Total Number of ED visits	2,013,002	2,059,669	2,152,450	2.32%	4.50%	2.19%
Total Charges of ED Visits	$1,202,510,000	$1,315,330,000	$1,559,100,000	2.32%	4.50%	2.19%
Total Number of ED visits within 30 Day of Inpatient Stay	65,430	67,212	66,167	2.32%	-1.55%	2.19%
Total Charges of ED visits within 30 Day of Inpatient Stay	$531,322,030	$573,698,529	$610,131,190	7.98%	6.35%	-1.63%
Total Number of Transfers	6470	6454	6309	-0.25%	-2.25%	-2.00%
Transfers as a % of Total Discharges	0.85%	0.85%	0.83%	-0.25%	-2.25%	-2.00%

Source: HSCRC, April 2013.

Note: Compiled from HSCRC Inpatient and Outpatient Data Sets. Average weights are calculated using FY2013 weights and applied to discharge APR-DRG SOI v29 for all years. Readmission counts include planned readmissions and oncology centers (differs from April draft recommendation). **Observation Rate Center was incorporated in FY2011 for most hospitals.

In Figure 3, we see that the decrease in statewide readmissions differed by payer. From FY2011 to FY2012 readmission decreased by 0.32 percentage points for all payers, 0.62 percentage points for Medicaid, and 0.44 percentage points for Medicare. Figure 3 also demonstrates that readmissions decreased for TPR hospitals as well as ARR hospitals.

Figure 3: Percent Readmissions by Payer and Hospital Payment Type Groups

	Fiscal Year			Percentage Point Difference		
Indicator	FY2010	FY2011	FY2012	FY2010-11	FY2011-12	Difference
Percent Readmissions - All Payer						
ARR	9.83%	9.71%	9.40%	-0.12%	-0.31%	-0.19%
TPR	10.40%	10.46%	9.79%	0.06%	-0.67%	-0.73%
Statewide	9.79%	9.69%	9.37%	-0.10%	-0.32%	-0.22%
Percent Readmissions - Medicaid						
ARR	9.80%	9.37%	8.73%	-0.43%	-0.64%	-0.21%
TPR	8.81%	7.95%	7.38%	-0.86%	-0.57%	0.29%
Statewide	9.39%	8.98%	8.36%	-0.41%	-0.62%	-0.21%
Percent Readmissions - Medicare						
ARR	13.79%	13.46%	13.07%	-0.33%	-0.39%	-0.06%
TPR	14.37%	14.55%	13.67%	0.18%	-0.88%	-1.06%
Statewide	13.81%	13.56%	13.12%	-0.25%	-0.44%	-0.19%

Source: HSCRC, April 2013.
Note: Compiled from HSCRC Inpatient and Outpatient Data Sets. Analysis did not remove exclusions or planned readmissions.

Recommendation: Implement a Shared Savings Policy

Based on feedback from CMS, HSCRC staff recommends the Commission include an explicit shared savings policy based on each hospital's readmissions.

Staff Reviewed Multiple Approaches

HSCRC staff reviewed multiple options for implementing a shared savings program in Maryland. Overall, HSCRC deemed it important to retain the fundamental structure of ARR, as the program has operated effectively in hospitals for the past two years. Therefore, staff has developed a recommended shared savings policy outside of the ARR policy.

The two major concepts most discussed were a scaling approach, similar to that employed under Medicare's Hospital Readmissions Reduction Program and a continuous improvement model. The scaling approach has a number of merits; most notably the similarity to CMS' Hospital Readmission Reduction program simplifies communications with CMS and strengthens Maryland's ability to gain exemption from CMS' program. However, HSCRC staff could not mitigate concerns over insufficient case mix adjustment and inability to track inter-hospital and out of state readmissions using HSCRC's all payer, case mix data.

An alternative shared savings model applies a continuous improvement mechanism. In this shared savings model, the HSCRC calculates a case mix adjusted readmission rate for each hospital for the base period and determines a required reduction to achieve the revenue for shared savings. The case mix adjustment is based on observed vs. expected readmissions, calculated using the statewide average readmission rate for each DRG SOI cell and aggregated for each hospital (see Figure 4).The risk adjusted readmission rate is calculated as observed/expected x state average readmission rate x normalization factor.[3] HSCRC staff then apply a shared savings benchmark, that is, the required readmission reduction to achieve the predetermined revenue for shared shavings, to the risk adjusted readmission rate to calculate the contribution from each hospital.

Implement a Continuous Improvement Shared Savings Policy

HSCRC staff recommends implementing the continuous improvement shared savings mechanism prospectively. This mechanism has a number of advantages:

- The mechanism is case mix adjusted by DRG-SOI (see Figure 4).
- A shared savings benchmark increases the incentive to reduce readmission rates. Hospitals that achieve readmissions reductions that are greater than the shared savings benchmark, would keep all of their savings, whereas hospitals that do not achieve the shared savings benchmark will not have any savings.
- Every hospital contributes to the shared savings; however, the shared savings are distributed in proportion to their case mix adjusted readmission rates in the base year.
- The shared savings amount is not related to actual reduction in readmissions during the rate year, hence providing equitable incentive across all hospitals. Hospitals that reduce their readmission rates better than the shared savings benchmark during the rate year will retain 100 percent of the difference between their actual reduction and the shared savings benchmark. They also would lower their readmission rate to be used as the base for the following rate year, hence lowering their contribution to the shared savings program for the following year.
- When applied prospectively, the HSCRC sets and may adjust the targeted dollar amount for shared savings, thus guaranteeing to Medicare and other payers a fixed amount of shared savings.
- As the shared savings contributions are calculated as a reduction in readmissions in the current ARR program, the methodology does not rank hospitals based on readmission rates, which require adjustment for inter hospital and out of state readmissions.
- As indicated above, while the shared savings policy is separate from ARR, the policy would promote the incentives of ARR. Shared savings mechanism requires hospitals to contribute a certain percentage from reductions, prospectively. For example, assuming a hospital with a 10 percent readmission rate has potential to gain 10 percent of revenue if it reduces all readmissions. If the shared savings readmission reduction is 3 percent, the hospital will contribute 10 percent x 3 percent=0.3 percent of its revenue to the shared savings program. For a hospital to receive additional revenue from ARR program, a hospital would need to reduce readmissions more than 3 percent.

[3] Risk adjusted rates are normalized to equalize observed vs. risk adjusted number of cases.

Figure 4: Risk Adjustment for a Shared Savings Continuous Improvement Mechanism. Hospital Readmission Rate and Ratio for FY2012, Based on APR-DRG and Severity, Including 0-1 Day Stays and Adjusted for Planned Admissions

Hospital ID	Hospital Name	Type	FY2012						
			Total Admissions	Expected Readmissions*	Observed Readmissions	Observed Rate	Readmission Ratio	Un-Normalized Risk Adjusted Rate*	Normalized Risk Adjusted Rate
			A	B	C	D = C/A	E = C/B	F = E*Total D	G = F*Total D/ Total F
210001	Meritus	TPR	17,499	1,453	1,468	8.39%	1.0105	8.78%	8.83%
210002	Univ. of Maryland	ARR	28,180	2,808	2,759	9.79%	0.9827	8.54%	8.59%
210003	Prince Georges	CPC	13,524	1,068	831	6.14%	0.7784	6.77%	6.80%
210004	Holy Cross	ARR	36,102	2,252	2,115	5.86%	0.9392	8.16%	8.21%
210005	Frederick Memorial	ARR	21,085	1,862	2,055	9.75%	1.1034	9.59%	9.64%
210006	Harford Memorial	ARR	5,279	577	556	10.53%	0.9633	8.37%	8.42%
210007	St. Josephs	ARR	18,144	1,444	1,282	7.07%	0.8877	7.72%	7.76%
210008	Mercy	ARR	19,146	1,372	1,315	6.87%	0.9585	8.33%	8.37%
210009	Johns Hopkins	ARR	45,148	4,244	4,652	10.30%	1.0962	9.53%	9.58%
210010	Dorchester General	TPR	2,843	316	293	10.31%	0.9267	8.05%	8.10%
210011	St. Agnes	ARR	20,603	1,803	1,718	8.34%	0.9529	8.28%	8.32%
210012	Sinai	ARR	28,821	2,601	2,665	9.25%	1.0246	8.91%	8.95%
210013	Bon Secours	ARR	6,659	792	835	12.54%	1.0537	9.16%	9.21%
210015	Franklin Square	ARR	24,346	2,187	2,280	9.36%	1.0426	9.06%	9.11%
210016	Washington Adventist	ARR	15,240	1,332	1,197	7.85%	0.8989	7.81%	7.85%
210017	Garrett County	TPR	2,421	187	137	5.66%	0.7307	6.35%	6.38%
210018	Montgomery General	ARR	9,793	897	866	8.84%	0.9656	8.39%	8.44%
210019	Peninsula Regional	ARR	21,065	1,870	1,903	9.03%	1.0178	8.85%	8.89%
210022	Suburban	ARR	13,735	1,263	1,091	7.94%	0.8635	7.51%	7.54%
210023	Anne Arundel	ARR	33,077	2,265	2,384	7.21%	1.0524	9.15%	9.19%
210024	Union Memorial	ARR	14,878	1,474	1,427	9.59%	0.9681	8.41%	8.46%
210027	Western Maryland	TPR	14,713	1,304	1,715	11.66%	1.3149	11.43%	11.49%
210028	St. Marys	ARR	8,578	717	877	10.22%	1.2233	10.63%	10.69%
210029	Johns Hopkins Bayview	ARR	21,526	1,871	2,043	9.49%	1.0917	9.49%	9.54%
210030	Chester River	TPR	2,798	274	297	10.61%	1.0849	9.43%	9.48%
210032	Union Hospital of Cecil	TPR	6,978	644	705	10.10%	1.0945	9.51%	9.56%
210033	Carroll County	TPR	13,103	1,138	1,261	9.62%	1.1083	9.63%	9.68%
210034	Harbor	ARR	11,545	974	922	7.99%	0.9469	8.23%	8.27%
210035	Civista	ARR	7,693	713	692	9.00%	0.9708	8.44%	8.48%
210037	Memorial of Easton	TPR	9,332	798	769	8.24%	0.9634	8.37%	8.42%
210038	Maryland General	ARR	9,356	1,001	981	10.49%	0.9799	8.52%	8.56%
210039	Calvert Memorial	TPR	8,192	700	597	7.29%	0.8527	7.41%	7.45%
210040	Northwest	ARR	13,493	1,477	1,687	12.50%	1.1419	9.93%	9.98%
210043	Baltimore Washington	ARR	19,169	1,889	1,974	10.30%	1.0448	9.08%	9.13%
210044	GBMC	ARR	22,337	1,552	1,248	5.59%	0.8043	6.99%	7.03%
210045	McCready	TPR	397	49	28	7.05%	0.5743	4.99%	5.02%
210048	Howard County	ARR	18,718	1,387	1,314	7.02%	0.9474	8.23%	8.28%
210049	Upper Chesapeake	ARR	14,671	1,271	1,258	8.57%	0.9898	8.60%	8.65%
210051	Doctors Community	ARR	11,868	1,290	1,198	10.09%	0.9286	8.07%	8.11%
210054	Southern Maryland	CPC	17,919	1,654	1,655	9.24%	1.0006	8.70%	8.74%
210055	Laurel Regional	CPC	6,455	517	347	5.38%	0.6713	5.83%	5.86%
210056	Good Samaritan	ARR	14,854	1,673	1,965	13.23%	1.1747	10.21%	10.26%
210057	Shady Grove	ARR	26,075	1,816	1,714	6.57%	0.9438	8.20%	8.25%
210058	Kernan	ARR	2,983	250	92	3.08%	0.3681	3.20%	3.22%
210060	Fort Washington	CPC	2,115	206	156	7.38%	0.7571	6.58%	6.61%
210061	Atlantic General	CPC	3,021	348	256	8.47%	0.7366	6.40%	6.44%
STATEWIDE TOTAL			**685,477**	**59,580**	**59,580**	**8.69%**	**1.0000**	**8.65%**	**8.69%**

* Based on Statewide readmissions by Initial Admission APR-DRG SOI for FY12

HSCRC staff modeled multiple scenarios within the continuous improvement shared savings mechanism.

Value of Shared Savings

Commission policy will determine the value of the shared savings dollar amount. HSCRC staff developed a model with a 0.3 percent and a 0.5 percent shared savings amount. See Figure 5 and Figure 6 in separate documents. The calculated shared savings benchmarks to achieve the modeled dollar amounts are 3.50 percent and 5.85 percent reductions in readmission rates, respectively. For FY 2014, HSCRC staff recommends providing for 0.3 percent shared savings.

Regardless of the value of the shared shavings for FY 2014, HSCRC staff recommends the Commission reevaluate the value of the shared savings on a regular basis, likely as an annual review in conjunction with update factor discussions.

Adjust for Planned Readmissions

Based on feedback from industry representatives, HSCRC staff concludes it prudent to remove planned readmissions for the continuous improvement shared savings logic. A planned readmission is an intentional readmission within 30 days of discharge from an acute care hospital that is a scheduled part of the patient's plan of care. Planned readmissions are not necessarily a signal of deficient quality of care and will not be reduced as a result of improvements in care; thus, they should be excluded from the calculation of shared savings program.

HSCRC staff identified and employed AHRQ's planned admissions logic, which identifies planned readmissions in claims used by CMS and endorsed by the National Quality Foundation. AHRQ 's algorithm defines "planned" readmissions as those in which one of a pre-specified list of procedures took place with no acute illness or complication, or those for maintenance chemotherapy or rehabilitation. Thus, planned admissions can be either a non-acute readmission in which one of 35 typically planned procedures occurs, or a readmission for maintenance chemotherapy. For example:

- A readmission with a discharge condition category of biliary tract disease that included a cholecystectomy would be considered **planned**
- A readmission with a discharge condition category of septicemia that included a cholecystectomy would be considered **unplanned**
- A readmission with a discharge condition category of "complications of surgical procedures or medical care" that included a cholecystectomy would be considered **unplanned**

Figure 7 provides the distribution of the top 40 most commonly planned admissions. Using fiscal year 2012 data, preliminary analyses of planned admissions and readmissions, yielded interesting results. In particular, there were 685,477 cases statewide of which 77,351 or 11 percent were planned admission cases. Forty of the most frequently planned admissions by APR-DRGs represented 89 percent of these cases. Readmissions for maintenance chemotherapy or rehabilitation APR-DRGs were 100 percent planned in the AHRQ logic.

Staff modeled the impact of adjusting for planned readmissions, so that these admissions become index admissions for a 30-day episode. As expected, the adjustment reduced the hospital readmission rates, as planned readmissions are reclassified as index admissions in the ARR episode logic in relation to the proportion of planned admissions as seen in Figure 8.

Figure 7: Distribution of 40 Most Commonly Planned Admission APR DRGs by Type of Admission for Fiscal Year 2012

APR DRG CODE	APR DRG CODE DESCRIPTION	TYPE OF ADMISSION					
		PLANNED		UNPLANNED			TOTAL
		NUMBER OF CASES	PERCENT OF CASES	NUMBER OF CASES	PERCENT OF CASES	NUMBER OF CASES	PERCENT OF TOTAL STATE CASES
985	REHAB - ORTHOPEDICS/ARTHRITIS	2,778	100.00%	0	0.00%	2,778	0.41%
693	CHEMOTHERAPY	2,613	100.00%	0	0.00%	2,613	0.38%
983	REHAB - STROKE	1,809	100.00%	0	0.00%	1,809	0.26%
860	REHABILITATION	920	100.00%	0	0.00%	920	0.13%
988	REHAB - BRAIN INJURY & RANCHO LEVELS (7,8)	866	100.00%	0	0.00%	866	0.13%
986	REHAB - NEUROLOGICAL	539	100.00%	0	0.00%	539	0.08%
987	REHAB - PAIN SYNDROMES	285	100.00%	0	0.00%	285	0.04%
982	REHAB - SPINAL CORD INJURY	220	100.00%	0	0.00%	220	0.03%
984	REHAB - AMPUTATION	161	100.00%	0	0.00%	161	0.02%
989	REHAB - LICENSED BRAIN INJURY (LEVELS 1 TO 6)	82	100.00%	0	0.00%	82	0.01%
980	REHAB DRG 850 (NATURE = REHAB) & LICENSED REHAB HOSPITAL	20	100.00%	0	0.00%	20	0.00%
3	BONE MARROW TRANSPLANT	6	100.00%	0	0.00%	6	0.00%
303	DORSAL & LUMBAR FUSION PROC FOR CURVATURE OF BACK	491	99.80%	1	0.20%	492	0.07%
482	TRANSURETHRAL PROSTATECTOMY	583	99.32%	4	0.68%	587	0.09%
262	CHOLECYSTECTOMY EXCEPT LAPAROSCOPIC	687	99.28%	5	0.72%	692	0.10%
263	LAPAROSCOPIC CHOLECYSTECTOMY	4,494	99.05%	43	0.95%	4,537	0.66%
480	MAJOR MALE PELVIC PROCEDURES	1,563	98.67%	21	1.33%	1,584	0.23%
512	UTERINE & ADNEXA PROCEDURES FOR NON-OVARIAN & NON-ADNEXAL	525	98.13%	10	1.87%	535	0.08%
511	UTERINE & ADNEXA PROCEDURES FOR OVARIAN & ADNEXAL MALIGNA	253	95.83%	11	4.17%	264	0.04%
304	DORSAL & LUMBAR FUSION PROC EXCEPT FOR CURVATURE OF BACK	4,110	92.88%	315	7.12%	4,425	0.65%
260	MAJOR PANCREAS, LIVER & SHUNT PROCEDURES	943	92.18%	80	7.82%	1,023	0.15%
302	KNEE JOINT REPLACEMENT	11,518	91.83%	1,025	8.17%	12,543	1.83%
163	CARDIAC VALVE PROCEDURES W/O CARDIAC CATHETERIZATION	989	91.24%	95	8.76%	1,084	0.16%
321	CERVICAL SPINAL FUSION & OTHER BACK/NECK PROC EXC DISC EX	3,247	90.09%	357	9.91%	3,604	0.53%
301	HIP JOINT REPLACEMENT	6,899	88.82%	868	11.18%	7,767	1.13%
261	MAJOR BILIARY TRACT PROCEDURES	129	87.76%	18	12.24%	147	0.02%
404	THYROID, PARATHYROID & THYROGLOSSAL PROCEDURES	935	87.55%	133	12.45%	1,068	0.16%
513	UTERINE & ADNEXA PROCEDURES FOR NON-MALIGNANCY EXCEPT LEI	3,217	86.22%	514	13.78%	3,731	0.54%
442	KIDNEY & URINARY TRACT PROCEDURES FOR MALIGNANCY	726	85.01%	128	14.99%	854	0.12%
310	INTERVERTEBRAL DISC EXCISION & DECOMPRESSION	2,372	84.23%	444	15.77%	2,816	0.41%
510	PELVIC EVISCERATION, RADICAL HYSTERECTOMY & OTHER RADICAL	202	81.12%	47	18.88%	249	0.04%
692	RADIOTHERAPY	37	80.43%	9	19.57%	46	0.01%
362	MASTECTOMY PROCEDURES	1,032	75.77%	330	24.23%	1,362	0.20%
166	CORONARY BYPASS W/O CARDIAC CATH OR PERCUTANEOUS CARDIAC	757	73.78%	269	26.22%	1,026	0.15%
228	INGUINAL, FEMORAL & UMBILICAL HERNIA PROCEDURES	555	71.06%	226	28.94%	781	0.11%
162	CARDIAC VALVE PROCEDURES W CARDIAC CATHETERIZATION	237	70.96%	97	29.04%	334	0.05%
305	AMPUTATION OF LOWER LIMB EXCEPT TOES	556	70.47%	233	29.53%	789	0.12%
519	UTERINE & ADNEXA PROCEDURES FOR LEIOMYOMA	2,032	68.76%	923	31.24%	2,955	0.43%
24	EXTRACRANIAL VASCULAR PROCEDURES	1,444	68.27%	671	31.73%	2,115	0.31%
120	MAJOR RESPIRATORY & CHEST PROCEDURES	840	61.99%	515	38.01%	1,355	0.20%
TOP 40 APR DRG TOTAL		**61,672**	**89.30%**	**7,392**	**10.70%**	**69,064**	**10.08%**
STATEWIDE TOTAL		**77,351**	**11.28%**	**608,126**	**88.72%**	**685,477**	**100.00%**

Source: HSCRC, April 2013.

Note: Compiled from HSCRC Inpatient Dataset with CPC exclusions.

Figure 8: Hospital Readmissions FY2012, Comparison of Planned Readmission Adjustment

Hospital ID	Hospital Name	Total Discharges	Percent Planned Admissions	Percent Readmissions		
				No Adjustment for Planned Readmissions	With Adjustment for Planned Readmissions	Impact of Planned Readmission Adjustment
210001	MERITUS	17,499	13.22%	8.85%	8.39%	-0.46%
210002	UNIVERSITY OF MARYLAND	28,180	12.60%	10.95%	9.79%	-1.16%
210003	PRINCE GEORGE	13,524	3.25%	6.40%	6.14%	-0.26%
210004	HOLY CROSS	36,102	5.69%	6.11%	5.86%	-0.25%
210005	FREDERICK MEMORIAL	21,085	7.98%	10.03%	9.75%	-0.28%
210006	HARFORD	5,279	3.50%	10.70%	10.53%	-0.17%
210007	ST. JOSEPH	18,144	18.55%	7.88%	7.07%	-0.81%
210008	MERCY	19,146	18.21%	7.95%	6.87%	-1.08%
210009	JOHNS HOPKINS	45,148	17.57%	11.41%	10.30%	-1.11%
210010	DORCHESTER GENERAL	2,843	2.99%	10.48%	10.31%	-0.17%
210011	ST. AGNES	20,603	8.85%	8.76%	8.34%	-0.42%
210012	SINAI	28,821	16.09%	10.38%	9.25%	-1.13%
210013	BON SECOURS	6,659	2.76%	12.94%	12.54%	-0.40%
210015	FRANKLIN SQUARE	24,346	7.66%	9.77%	9.36%	-0.41%
210016	WASHINGTON ADVENTIST	15,240	8.20%	8.33%	7.85%	-0.48%
210017	GARRETT COUNTY	2,421	9.38%	5.95%	5.66%	-0.29%
210018	MONTGOMERY GENERAL	9,793	6.57%	9.04%	8.84%	-0.20%
210019	PENINSULA GENERAL	21,065	12.58%	9.79%	9.03%	-0.76%
210022	SUBURBAN	13,735	20.30%	8.59%	7.94%	-0.65%
210023	ANNE ARUNDEL	33,077	13.41%	7.72%	7.21%	-0.51%
210024	UNION MEMORIAL	14,878	20.92%	10.19%	9.59%	-0.60%
210027	WESTERN MARYLAND	14,713	11.97%	12.43%	11.66%	-0.77%
210028	ST. MARY	8,578	6.37%	10.43%	10.22%	-0.21%
210029	HOPKINS BAYVIEW MED CTR	21,526	8.43%	9.76%	9.49%	-0.27%
210030	CHESTER RIVER	2,798	5.47%	10.79%	10.61%	-0.18%
210032	UNION HOSPITAL OF CECIL	6,978	5.80%	10.48%	10.10%	-0.38%
210033	CARROLL COUNTY	13,103	10.14%	9.96%	9.62%	-0.34%
210034	HARBOR	11,545	12.72%	8.51%	7.99%	-0.52%
210035	CIVISTA	7,693	6.19%	9.20%	9.00%	-0.20%
210037	MEMORIAL AT EASTON	9,332	13.35%	8.94%	8.24%	-0.70%
210038	MARYLAND GENERAL	9,356	3.66%	10.78%	10.49%	-0.29%
210039	CALVERT	8,192	6.01%	7.42%	7.29%	-0.13%
210040	NORTHWEST	13,493	4.82%	12.69%	12.50%	-0.19%
210043	BALTIMORE WASHINGTON	19,169	11.59%	10.88%	10.30%	-0.58%
210044	G.B.M.C.	22,337	11.66%	6.11%	5.59%	-0.52%
210045	MCCREADY	397	1.76%	7.05%	7.05%	0.00%
210048	HOWARD COUNTY	18,718	6.10%	7.24%	7.02%	-0.22%
210049	UPPER CHESAPEAKE HEALTH	14,671	10.11%	8.92%	8.57%	-0.35%
210051	DOCTORS COMMUNITY	11,868	8.56%	10.49%	10.09%	-0.40%
210054	SOUTHERN MARYLAND	17,919	4.68%	9.48%	9.24%	-0.24%
210055	LAUREL REGIONAL	6,455	9.74%	8.04%	5.38%	-2.66%
210056	GOOD SAMARITAN	14,854	19.49%	13.83%	13.23%	-0.60%
210057	SHADY GROVE	26,075	6.97%	6.90%	6.57%	-0.33%
210058	KERNAN	2,983	91.92%	7.58%	3.08%	-4.50%
210060	FT. WASHINGTON	2,115	10.87%	7.52%	7.38%	-0.14%
210061	ATLANTIC GENERAL	3,021	10.69%	8.74%	8.47%	-0.27%
STATE TOTAL		**685,477**	**11.28%**	**9.27%**	**8.69%**	**-0.58%**

Exclude Hospitals if Engaged in a Voluntary Agreement which Includes an Explicit Shared Savings Mechanism

HSCRC staff recommends the Commission exclude hospitals engaged in voluntary agreements from the shared shavings policy, provided the voluntary agreements include an explicit shared savings mechanism. For example, HSCRC and TPR hospitals are currently engaged in agreement negotiations. HSCRC staff intend for these voluntary agreements to include a shared savings mechanism. Provided that the renegotiated TPR agreements include a share savings mechanism, the TPR hospitals would be excluded from this statewide shared savings policy. Current ARR agreements do not include a shared savings mechanism and, therefore, ARR hospitals would be subject to this statewide shared savings policy.

Note that in determining the statewide expected readmission rates (discussed above), HSCRC staff recommends including all acute care hospitals. This is similar to methodology for CPE statewide weight development.

Coordinate with Lag Timeframes

While HSCRC staff modeled the shared savings policy on a fiscal year basis, we understand that our approach to shared savings must align with data lags and other policies being implemented by the HSCRC. It is likely that the actual timeframe for the first shared savings will be calendar year 2012 for implementation prospectively.

Interaction with Model Design Proposal

Shared savings is also an explicit component of Maryland proposed Model Design demonstration. In our submission the CMS, Maryland assured a 0.5 percent savings from shared savings beginning in FY 2015.

Appendix A
MHA Discussion Document

Maryland
Hospital Association

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

April 18, 2013

Nduka Udom
Associate Director, Research & Methodology
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215-2299

Dear Andy:

On behalf of the 66 members of the Maryland Hospital Association (MHA), we appreciate the opportunity to comment on the Health Services Cost Review Commission (HSCRC) recommendations on Modifications to the Admission-Readmission Revenue (ARR) Methodology presented at the April 10 public meeting. We appreciate the thoughtful consideration HSCRC staff has put into the recommendations to modify the ARR program. We understand modifications are being made for one year only and support many of the changes to the program for fiscal year 2014 as proposed by the HSCRC staff. We are concerned about the recommendation to cancel the ARR contracts and the level of shared savings with payors.

First, we'd like to highlight the recommendations we support. The proposed modifications to the ARR methodology maintain the alignment of clinical and financial incentives to reduce readmissions, unlike the Medicare readmissions payment policy which assesses penalties on hospitals with higher than expected readmission rates and does nothing to counter the disincentive and lost revenue as a result of readmission reductions. Successful readmission reduction strategies save Medicare and other payors not only through reductions in readmissions, but also as a result of fewer admissions, emergency department visits, and observation stays as a result of better care coordination and more engaged follow-up after discharge.

MHA supports the following points in the staff recommendation:

- Include one-day stays in the ARR program and the charge-per-episode weight calculations.
- Exclude planned readmissions following the algorithm used in the Medicare methodology. While excluding planned readmissions from the readmission count and considering them initial admissions adds complexity to a methodology that is already challenging to monitor, excluding planned readmissions increases the understanding and confidence in the methodology among clinicians.
- Set individual hospital targets for readmission reductions based on expected values and the prior calendar year's statewide performance. The methodology proposed to generate the 0.3 percent savings required by the Centers for Medicare & Medicaid Services (CMS) sets higher readmission reduction targets for hospitals that are not performing as well as expected. Calculation of statewide performance should include hospitals paid under the Total Patient

- more -

Appendix A
MHA Discussion Document

Revenue system. Although hospitals operating under a global budget may have inherent differences in readmission trends due to isolated geography, proximity to state borders, and a much stronger incentive to reduce readmissions, all hospitals have opportunities to reduce readmissions. As hospitals continue to reduce readmissions, this methodology will need to be revisited. At some point, most of the avoidable readmissions will be culled from the system and further reductions would harm patient outcomes.

- Exclude hospice cases using "service code 10" to identify hospice cases. Hospice cases services are fundamentally different from acute care and by contract, are paid at different rates. Best practice is to discharge from acute care and admit to hospice when a person's care transitions from acute care to hospice, a practice that makes these cases easily identifiable.
- Palliative care can be provided concurrently with curative care and should continue to be included in the charge-per-episode methodology.
- Set statewide trim points for each All Patient Refined Diagnostic Related Group and Severity of Illness cell. Statewide trim points effectively increase the charge level at which cases are classified as outliers and reduce the complexity of administering and monitoring the system. Hospitals with relatively low charge-per-case targets will benefit from a slight increase to those targets, and at the same time bear greater risk should they experience an increase in the number of outlier cases. For hospitals with the lowest charge targets, the increase in the outlier threshold represents a substantial risk should the number of outlier cases increase. This risk is compounded as inpatient volumes decline or remain flat. It takes many more included cases to break even on the additional outlier case. HSCRC staff has stated that after reviewing historical data, most low charge hospitals have been harmed by the hospital-specific trim point policy. We would request HSCRC staff share that analysis. Likewise, we would ask that the HSCRC retrospectively evaluate the move to statewide trim points one and two years after implementation.

Although we support many of the technical components of the recommendation, we have significant concerns with parts of the recommendations. HSCRC staff proposes to share between 0.3 percent and 0.5 percent of all-payor inpatient revenue with Medicare and other payors. Nationally, the Medicare program expects to save approximately 0.3 percent of Medicare base payments. Shared savings at the 0.3 percent level is a substantially greater amount in Maryland as it is a percentage of all inpatient revenue compared to national Medicare-only base payments, which do not include additional payments for medical education, disproportionate share, and other add-ons to Medicare Diagnosis Related Group payments. Readmission reduction targets should be set to generate no more than 0.3 percent of inpatient revenue savings across all payors.

The second and related concern is the recommendation to terminate all 31 three-year ARR contracts for the entire third year. The ARR contract states that the HSCRC can terminate the agreements for only one reason — "for cause." The HSCRC's stated "cause" for cancelling the contracts is a "strong indication" from CMS staff that in order to meet the "meet or exceed" requirement in the Affordable Care Act for Maryland's exemption from the Medicare readmission program, the HSCRC would have to add an explicit shared savings element to the existing ARR program. This would mark the second, and more onerous, change in the three-year agreement in the first two years of the agreements. MHA objects for practical and legal reasons.

- more -

Appendix A
MHA Discussion Document

As a practical matter, the Maryland agreements cover all readmissions, compared to the Medicare program which only looks at three diagnoses: acute myocardial infarction, heart failure, and pneumonia. The Maryland program's larger sweep requires more commitment and resources than does Medicare's, and the third year was always likely to be the year in which the greatest opportunity for improvement existed. Similarly, a program that focuses on reducing readmissions on all Medicare cases has the capability of producing significantly greater reductions than a program measured only by a limited number of diagnoses. Last, but certainly far from least, cancelling contracts so soon at the start of a significant program sends the worst possible message to hospitals at a time when co-operation is needed.

From a legal perspective, MHA does not believe the HSCRC has the right to walk away from its contractual obligations. Indeed, the recommendation would terminate the contracts altogether and replace them with a policy that compelled hospitals to meet the new requirements. Replacing contractual relationships with mandates sends a message too.

The HSCRC can contract, but it does not escape the laws of contract just because it is a governmental entity. In Maryland, terminating a contract for cause has generally required the non-cancelling party to have breached the contract in some way. *Bd of Street Com'rs of Hagerstown v. Williams*, 96 Md. 532 (1903); *Chai Management, Inc. v. Leibowitz*, 50 Md. App. 504 (1982). The stated cause, not any hospital failure, but the act of a governmental entity or change in law — Medicare indicated the current ARR program "may not meet the Affordable Care Act requirement for financial savings." This might justify cancelling the remainder of the contract if indeed Medicare's contemplated action was an unforeseen and unforeseeable event that was not, and could not have been, known to be a possible result when the contracts were signed under the legal impossibility or commercial frustration doctrines. That is not the case. The Affordable Care Act provision in question was enacted in March 2010, both requiring a readmission program that applied to Maryland hospitals and giving the Secretary of the Department of Health & Human Services the authority to grant Maryland a waiver. The ARR policy was adopted eight months later, and the contracts were not signed until July 2011. The timing confirms that the HSCRC knew, or should have known, what CMS' position might be. A party to a contract cannot be excused from performance because of an intervening act of government if the action was reasonably foreseeable. In this case it was all but certain. The HSCRC could have inserted a cancellation right referencing the known potential Medicare problem, but it did not. The 31 hospitals have the right to insist that their contracts be honored. Individual hospitals are left with a difficult choice — agreeing to cancellation of a contract at a time when they need to know HSCRC actions are fair and predictable, or risk greater uncertainty and disruption by possibly losing the exemption from the Medicare readmissions program.

I appreciate your consideration of our comments and would be happy to respond to any questions you may have about them. I can be reached at 410-379-6200.

Sincerely,

Traci La Valle, Vice President, Financial Policy & Advocacy

cc: Commissioners, HSCRC

Figure 5: Calculation of Shared Savings Based on Inpatient Revenue Savings of 0.3% of Total Inpatient Revenue

Hospital ID	Hospital Name	Payment Type	*Rate Year 2013 Charge Target Information			FY12 Total Admissions (Including One Day Stays)	Average Approved Charge	FY12 Risk Adjusted Rate	Risk Adjusted Reduction Rate (Reduction Rate of 3.50%)	Reduced Readmission Rate for FY13	Risk Adjusted Number of Readmission in FY12	Risk Adjusted Number of Readmissions for FY13	Reduction in Readmissions for FY13	Shared Savings	Percent Reduction in Rate Year 2013 Approved Revenue
			Number of Included Cases	CPC/CPE Target	Approved Revenue under CPC/CPE Target										
			A	B	C = A*B	D	E = C/D	F	G = F*3.50%	H = F-G	I = F*D	J = H*D	K = J-I	L = K*E	M = L/C
210002	Univ. of Maryland Medical System	ARR	20,191	$29,726	$600,197,666	28,180	$21,299	8.59%	0.3005%	8.28%	2,419	2,335	(85)	-1,803,502	-0.3005%
210003	Prince Georges Hospital	CPC	11,879	$13,739	$163,205,581	13,524	$12,068	6.80%	0.2380%	6.56%	920	888	(32)	-388,454	-0.2380%
210004	Holy Cross Hospital of Silver Spring	ARR	30,114	$9,176	$276,326,064	36,102	$7,654	8.21%	0.2872%	7.92%	2,962	2,859	(104)	-793,563	-0.2872%
210005	Frederick Memorial Hospital	ARR	16,341	$10,361	$169,309,101	21,085	$8,030	9.64%	0.3374%	9.30%	2,033	1,961	(71)	-571,235	-0.3374%
210006	Harford Memorial Hospital	ARR	3,904	$10,885	$42,495,040	5,279	$8,050	8.42%	0.2946%	8.12%	444	429	(16)	-125,170	-0.2946%
210007	St. Josephs Hospital	ARR	13,989	$12,911	$180,611,979	18,144	$9,954	7.76%	0.2714%	7.48%	1,407	1,358	(49)	-490,246	-0.2714%
210008	Mercy Medical Center, Inc.	ARR	15,169	$12,654	$191,948,526	19,146	$10,026	8.37%	0.2931%	8.08%	1,603	1,547	(56)	-562,572	-0.2931%
210009	Johns Hopkins Hospital	ARR	32,298	$25,008	$807,708,384	45,148	$17,890	9.58%	0.3352%	9.24%	4,324	4,172	(151)	-2,707,358	-0.3352%
210011	St. Agnes Hospital	ARR	15,733	$13,333	$209,768,089	20,603	$10,181	8.32%	0.2914%	8.03%	1,715	1,655	(60)	-611,207	-0.2914%
210012	Sinai Hospital	ARR	21,402	$16,960	$362,977,920	28,821	$12,594	8.95%	0.3133%	8.64%	2,580	2,490	(90)	-1,137,197	-0.3133%
210013	Bon Secours Hospital	ARR	5,066	$13,953	$70,685,898	6,659	$10,615	9.21%	0.3222%	8.88%	613	592	(21)	-227,746	-0.3222%
210015	Franklin Square Hospital	ARR	18,614	$12,987	$241,740,018	24,346	$9,929	9.11%	0.3188%	8.79%	2,218	2,140	(78)	-770,668	-0.3188%
210016	Washington Adventist Hospital	ARR	11,817	$13,118	$155,015,406	15,240	$10,172	7.85%	0.2749%	7.58%	1,197	1,155	(42)	-426,076	-0.2749%
210018	Montgomery General Hospital	ARR	7,703	$10,352	$79,741,456	9,793	$8,143	8.44%	0.2953%	8.14%	826	797	(29)	-235,441	-0.2953%
210019	Peninsula Regional Medical Center	ARR	16,602	$13,219	$219,461,838	21,065	$10,418	8.89%	0.3112%	8.58%	1,873	1,808	(66)	-683,003	-0.3112%
210022	Suburban Hospital Association,Inc	ARR	10,041	$15,056	$151,177,296	13,735	$11,007	7.54%	0.2640%	7.28%	1,036	1,000	(36)	-399,163	-0.2640%
210023	Anne Arundel General Hospital	ARR	24,803	$10,118	$250,956,754	33,077	$7,587	9.19%	0.3218%	8.87%	3,041	2,935	(106)	-807,572	-0.3218%
210024	Union Memorial Hospital	ARR	10,775	$20,021	$215,726,275	14,878	$14,500	8.46%	0.2960%	8.16%	1,258	1,214	(44)	-638,594	-0.2960%
210028	St. Marys Hospital	ARR	6,070	$8,871	$53,846,970	8,578	$6,277	10.69%	0.3741%	10.31%	917	885	(32)	-201,417	-0.3741%
210029	Johns Hopkins Bayview Med. Center	ARR	16,784	$14,831	$248,923,504	21,526	$11,564	9.54%	0.3338%	9.20%	2,053	1,981	(72)	-830,942	-0.3338%
210034	Harbor Hospital Center	ARR	8,552	$13,590	$116,221,680	11,545	$10,067	8.27%	0.2895%	7.98%	955	922	(33)	-336,506	-0.2895%
210035	Civista Medical Center	ARR	6,074	$10,005	$60,770,370	7,693	$7,899	8.48%	0.2968%	8.18%	652	630	(23)	-180,394	-0.2968%
210038	Maryland General Hospital	ARR	7,235	$14,626	$105,819,110	9,356	$11,310	8.56%	0.2996%	8.26%	801	773	(28)	-317,064	-0.2996%
210040	Northwest Hospital Center, Inc.	ARR	9,611	$12,626	$121,348,486	13,493	$8,993	9.98%	0.3492%	9.63%	1,346	1,299	(47)	-423,705	-0.3492%
210043	Baltimore Washington Medical Center	ARR	14,105	$13,092	$184,662,660	19,169	$9,633	9.13%	0.3195%	8.81%	1,750	1,688	(61)	-589,948	-0.3195%
210044	Greater Baltimore Medical Center	ARR	18,486	$10,007	$184,989,402	22,337	$8,282	7.03%	0.2459%	6.78%	1,570	1,515	(55)	-454,953	-0.2459%
210048	Howard County General Hospital	ARR	15,573	$9,426	$146,791,098	18,718	$7,842	8.28%	0.2897%	7.99%	1,549	1,495	(54)	-425,240	-0.2897%
210049	Upper Chesapeake Medical Center	ARR	10,936	$10,554	$115,418,544	14,671	$7,867	8.65%	0.3027%	8.34%	1,269	1,224	(44)	-349,321	-0.3027%
210051	Doctors Community Hospital	ARR	8,778	$13,612	$119,486,136	11,868	$10,068	8.11%	0.2839%	7.83%	963	929	(34)	-339,272	-0.2839%
210054	Southern Maryland Hospital	CPC	15,226	$9,532	$145,134,232	17,919	$8,099	8.74%	0.3060%	8.44%	1,566	1,512	(55)	-444,050	-0.3060%
210055	Laurel Regional Hospital	CPC	5,798	$9,203	$53,358,994	6,455	$8,266	5.86%	0.2053%	5.66%	379	365	(13)	-109,528	-0.2053%
210056	Good Samaritan Hospital	ARR	10,553	$16,387	$172,932,011	14,854	$11,642	10.26%	0.3592%	9.90%	1,524	1,471	(53)	-621,160	-0.3592%
210057	Shady Grove Adventist Hospital	ARR	21,067	$9,269	$195,270,023	26,075	$7,489	8.25%	0.2886%	7.96%	2,150	2,075	(75)	-563,530	-0.2886%
210058	James Lawrence Kernan Hospital	ARR	2,656	$17,263	$45,850,528	2,983	$15,371	3.22%	0.1126%	3.10%	96	93	(3)	-51,607	-0.1126%
210060	Fort Washington Medical Center	CPC	1,879	$8,648	$16,249,592	2,115	$7,683	6.61%	0.2315%	6.38%	140	135	(5)	-37,618	-0.2315%
210061	Atlantic General Hospital	CPC	2,563	$13,180	$33,780,340	3,021	$11,182	6.44%	0.2252%	6.21%	194	188	(7)	-76,085	-0.2252%
Total			468,387	$13,899	$6,509,906,971	607,201	$10,721	8.69%	0.3042%	8.39%	52,344	50,511	(1,832)	-19,731,104	-0.3031%

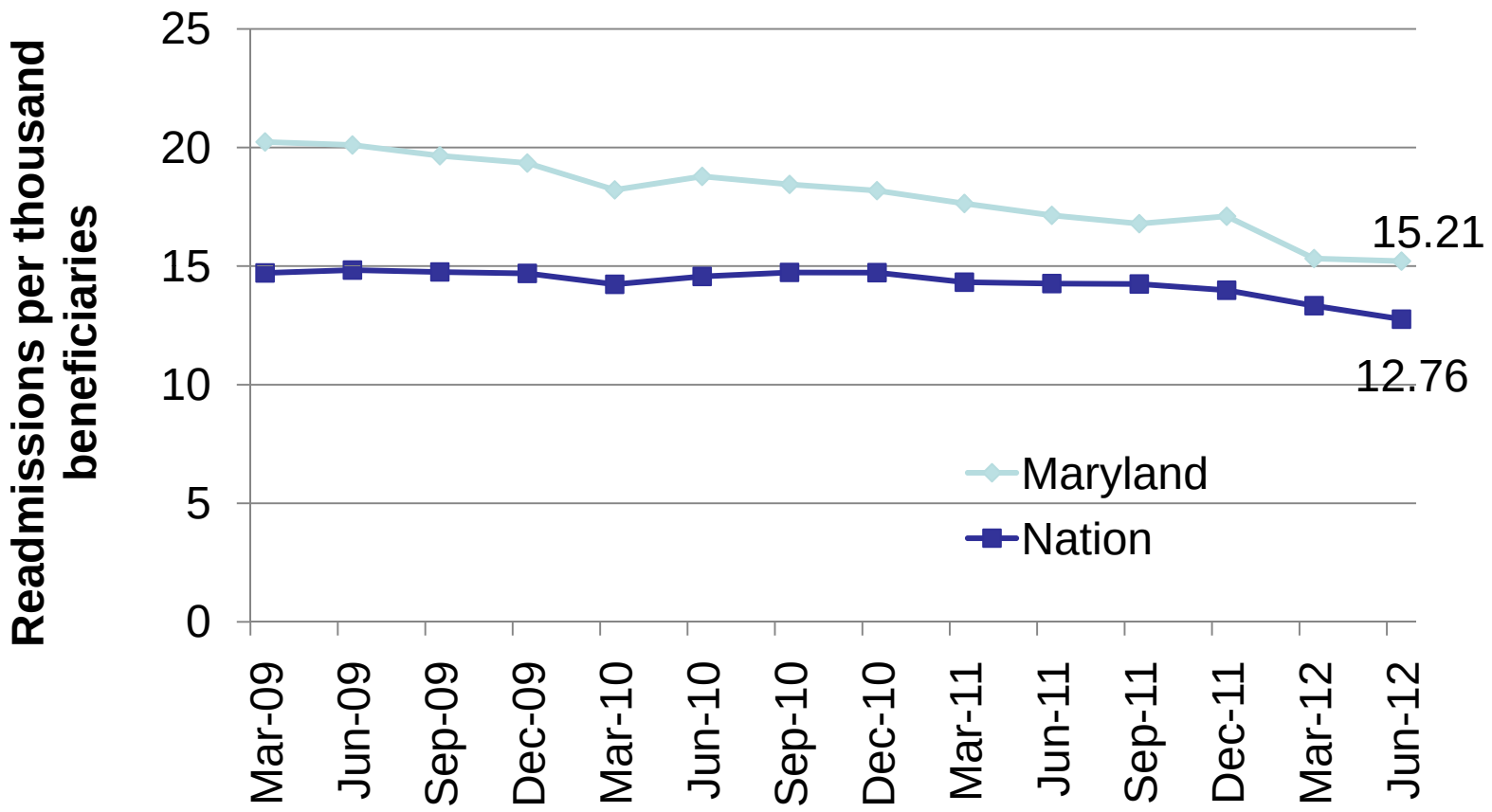
* Rate Year 2013 Charge Targets and Related Data Elements, Effective July 1, 2012

Figure 6: Calculation of Shared Savings Based on Inpatient Revenue Savings of 0.5% of Total Inpatient Revenue

Hospital ID	Hospital Name	Payment Type	*Rate Year 2013 Charge Target Information			FY12 Total Admissions (Including One Day Stays)	Average Approved Charge	FY12 Risk Adjusted Rate	Risk Adjusted Reduction Rate (Reduction Rate of 5.85%)	Reduced Readmission Rate for FY13	Risk Adjusted Number of Readmission in FY12	Risk Adjusted Number of Readmissions for FY13	Reduction in Readmissions for FY13	Shared Savings	Percent Reduction in Rate Year 2013 Approved Revenue
			Number of Included Cases	CPC/CPE Target	Approved Revenue under CPC/CPE Target										
			A	B	C = A*B	D	E = C/D	F	G = F*5.85%	H = F-G	I = F*D	J = H*D	K = J-I	L = K*E	M = L/C
210002	Univ. of Maryland Medical System	ARR	20,191	$29,726	$600,197,666	28,180	$21,299	8.59%	0.5022%	8.08%	2,419	2,278	(142)	-3,014,424	-0.5022%
210003	Prince Georges Hospital	CPC	11,879	$13,739	$163,205,581	13,524	$12,068	6.80%	0.3978%	6.40%	920	866	(54)	-649,272	-0.3978%
210004	Holy Cross Hospital of Silver Spring	ARR	30,114	$9,176	$276,326,064	36,102	$7,654	8.21%	0.4800%	7.73%	2,962	2,789	(173)	-1,326,383	-0.4800%
210005	Frederick Memorial Hospital	ARR	16,341	$10,361	$169,309,101	21,085	$8,030	9.64%	0.5639%	9.08%	2,033	1,914	(119)	-954,778	-0.5639%
210006	Harford Memorial Hospital	ARR	3,904	$10,885	$42,495,040	5,279	$8,050	8.42%	0.4923%	7.92%	444	418	(26)	-209,213	-0.4923%
210007	St. Josephs Hospital	ARR	13,989	$12,911	$180,611,979	18,144	$9,954	7.76%	0.4537%	7.30%	1,407	1,325	(82)	-819,411	-0.4537%
210008	Mercy Medical Center, Inc.	ARR	15,169	$12,654	$191,948,526	19,146	$10,026	8.37%	0.4899%	7.88%	1,603	1,509	(94)	-940,299	-0.4899%
210009	Johns Hopkins Hospital	ARR	32,298	$25,008	$807,708,384	45,148	$17,890	9.58%	0.5602%	9.02%	4,324	4,071	(253)	-4,525,155	-0.5602%
210011	St. Agnes Hospital	ARR	15,733	$13,333	$209,768,089	20,603	$10,181	8.32%	0.4870%	7.84%	1,715	1,615	(100)	-1,021,588	-0.4870%
210012	Sinai Hospital	ARR	21,402	$16,960	$362,977,920	28,821	$12,594	8.95%	0.5237%	8.43%	2,580	2,429	(151)	-1,900,744	-0.5237%
210013	Bon Secours Hospital	ARR	5,066	$13,953	$70,685,898	6,659	$10,615	9.21%	0.5385%	8.67%	613	577	(36)	-380,661	-0.5385%
210015	Franklin Square Hospital	ARR	18,614	$12,987	$241,740,018	24,346	$9,929	9.11%	0.5329%	8.58%	2,218	2,088	(130)	-1,288,117	-0.5329%
210016	Washington Adventist Hospital	ARR	11,817	$13,118	$155,015,406	15,240	$10,172	7.85%	0.4594%	7.39%	1,197	1,127	(70)	-712,156	-0.4594%
210018	Montgomery General Hospital	ARR	7,703	$10,352	$79,741,456	9,793	$8,143	8.44%	0.4935%	7.94%	826	778	(48)	-393,523	-0.4935%
210019	Peninsula Regional Medical Center	ARR	16,602	$13,219	$219,461,838	21,065	$10,418	8.89%	0.5202%	8.37%	1,873	1,764	(110)	-1,141,591	-0.5202%
210022	Suburban Hospital Association,Inc	ARR	10,041	$15,056	$151,177,296	13,735	$11,007	7.54%	0.4413%	7.10%	1,036	976	(61)	-667,172	-0.4413%
210023	Anne Arundel General Hospital	ARR	24,803	$10,118	$250,956,754	33,077	$7,587	9.19%	0.5379%	8.66%	3,041	2,863	(178)	-1,349,798	-0.5379%
210024	Union Memorial Hospital	ARR	10,775	$20,021	$215,726,275	14,878	$14,500	8.46%	0.4948%	7.96%	1,258	1,185	(74)	-1,067,364	-0.4948%
210028	St. Marys Hospital	ARR	6,070	$8,871	$53,846,970	8,578	$6,277	10.69%	0.6252%	10.06%	917	863	(54)	-336,654	-0.6252%
210029	Johns Hopkins Bayview Med. Center	ARR	16,784	$14,831	$248,923,504	21,526	$11,564	9.54%	0.5579%	8.98%	2,053	1,933	(120)	-1,388,859	-0.5579%
210034	Harbor Hospital Center	ARR	8,552	$13,590	$116,221,680	11,545	$10,067	8.27%	0.4839%	7.79%	955	899	(56)	-562,445	-0.4839%
210035	Civista Medical Center	ARR	6,074	$10,005	$60,770,370	7,693	$7,899	8.48%	0.4962%	7.99%	652	614	(38)	-301,516	-0.4962%
210038	Maryland General Hospital	ARR	7,235	$14,626	$105,819,110	9,356	$11,310	8.56%	0.5008%	8.06%	801	754	(47)	-529,950	-0.5008%
210040	Northwest Hospital Center, Inc.	ARR	9,611	$12,626	$121,348,486	13,493	$8,993	9.98%	0.5836%	9.39%	1,346	1,267	(79)	-708,193	-0.5836%
210043	Baltimore Washington Medical Center	ARR	14,105	$13,092	$184,662,660	19,169	$9,633	9.13%	0.5340%	8.59%	1,750	1,647	(102)	-986,055	-0.5340%
210044	Greater Baltimore Medical Center	ARR	18,486	$10,007	$184,989,402	22,337	$8,282	7.03%	0.4111%	6.62%	1,570	1,478	(92)	-760,421	-0.4111%
210048	Howard County General Hospital	ARR	15,573	$9,426	$146,791,098	18,718	$7,842	8.28%	0.4842%	7.79%	1,549	1,459	(91)	-710,759	-0.4842%
210049	Upper Chesapeake Medical Center	ARR	10,936	$10,554	$115,418,544	14,671	$7,867	8.65%	0.5059%	8.14%	1,269	1,194	(74)	-583,865	-0.5059%
210051	Doctors Community Hospital	ARR	8,778	$13,612	$119,486,136	11,868	$10,068	8.11%	0.4746%	7.64%	963	906	(56)	-567,068	-0.4746%
210054	Southern Maryland Hospital	CPC	15,226	$9,532	$145,134,232	17,919	$8,099	8.74%	0.5114%	8.23%	1,566	1,475	(92)	-742,197	-0.5114%
210055	Laurel Regional Hospital	CPC	5,798	$9,203	$53,358,994	6,455	$8,266	5.86%	0.3431%	5.52%	379	356	(22)	-183,068	-0.3431%
210056	Good Samaritan Hospital	ARR	10,553	$16,387	$172,932,011	14,854	$11,642	10.26%	0.6004%	9.66%	1,524	1,435	(89)	-1,038,225	-0.6004%
210057	Shady Grove Adventist Hospital	ARR	21,067	$9,269	$195,270,023	26,075	$7,489	8.25%	0.4824%	7.76%	2,150	2,024	(126)	-941,900	-0.4824%
210058	James Lawrence Kernan Hospital	ARR	2,656	$17,263	$45,850,528	2,983	$15,371	3.22%	0.1881%	3.03%	96	90	(6)	-86,258	-0.1881%
210060	Fort Washington Medical Center	CPC	1,879	$8,648	$16,249,592	2,115	$7,683	6.61%	0.3869%	6.23%	140	132	(8)	-62,876	-0.3869%
210061	Atlantic General Hospital	CPC	2,563	$13,180	$33,780,340	3,021	$11,182	6.44%	0.3765%	6.06%	194	183	(11)	-127,170	-0.3765%
Total			468,387	$13,899	$6,509,906,971	607,201	$10,721	8.69%	0.5085%	8.18%	52,344	49,281	(3,062)	-32,979,131	-0.5066%

* Rate Year 2013 Charge Targets and Related Data Elements, Effective July 1, 2012

Medicare Readmissions in Maryland are Declining Faster than the Nation



Data Source: Delmarva Foundation

Data are seasonally adjusted

Maryland Hospital Association

Final Recommendation on Technical Modifications to the Charge Per Case/Charge Per Episode Policy

Health Services Cost Review Commission

4160 Patterson Avenue Baltimore, MD 21215

(410) 764-2605

May 1, 2013

This represents the recommendation as approved by the Commission on May 1, 2013.

Introduction

This final recommendation proposes that the Commission modify the charge per episode/charge per case (CPC/CPE) methodology to include zero and one day stays into the CPC/CPE. This recommendation also confirms the explicit removal of contracted hospice cases from the CPC/CPE.

Past Commission Actions

In 2010, zero and one day stays accounted for 22.48 percent of Maryland all payer admissions, compared with 16.58 percent in national all payer data.[1] Based on the high rate of zero and one day stays in Maryland hospitals, at the May 2010 public Commission meeting, the Commission excluded zero and one day stays from the CPC. CPE methodology, applied in FY 2012 for the ARR program, utilized all CPC exclusions, and therefore also excluded zero and one day stays from the CPE.

HSCRC staff reported to the Commission on the potential to reintroduce zero and one day stays into the CPC/CPE at the November 7, 2012 and February 6, 2013 Commission meetings. Commission staff also recommended the reintroduction of zero and one day stays as a component of a draft recommendation presented at the April 10, 2013 public Commission meeting.

Stakeholder Process

HSCRC staff engaged industry representatives to discuss policy and methodological modifications, including the reintroduction of zero and one day stays into the CPC/CPE, as part of an ARR workgroup process. HSCRC staff held our first workgroup on January 24, 2013 with hospital representatives, followed by a payer discussion on January 31. HSCRC staff met with representatives from both hospitals and payers several additional times in February and March. Subsequent to presenting the draft recommendation, HSCRC staff discussed recommendation modifications with a number of hospital representatives. We have included a letter from MHA in Appendix A.

Background

Zero and One Day Stay Cases

Currently, short stay cases are excluded from the CPC/CPE methodology. HSCRC staff recommends reincorporating these into the methodology to prevent them from representing pass-through revenue to the system and to minimize their impact on the current waiver. Further, a consistent treatment of inpatient cases would make the existing model more comprehensive. Technically, folding short stay cases into the model is straightforward, with CPE targets and case mix weights reflecting the change when rebased at the beginning of the rate year. Figure 1 demonstrates hospital readmissions with and without one day stays.

[1] Final Staff Recommendation: Rate Methods and Financial Incentives relating to One Day Length of Stay and Denied Cases in the Maryland Hospital Industry, Health Services Cost Review Commission, May 5, 2010.

Figure 1. Hospital Readmissions for FY2011 and FY2012, Comparison of One Day Stays

Hospital ID	Hospital Name	FY2011				FY2012			
		Without One Day Stays		With One Day Stays		Without One Day Stays		With One Day Stays	
		Total Discharges	Percent Readms	Total Discharges	Percent Readms	Total Discharges	Percent Readms	Total Discharges	Percent Readms
210001	MERITUS	15,502	8.37%	18,083	9.25%	15,359	8.26%	17,499	8.85%
210002	UNIV. OF MARYLAND	23,157	10.88%	30,247	11.77%	22,653	10.31%	28,180	10.95%
210003	PRINCE GEORGE	12,936	5.93%	15,088	6.76%	11,895	5.67%	13,524	6.40%
210004	HOLY CROSS	32,565	5.53%	37,163	6.51%	31,936	5.36%	36,102	6.11%
210005	FREDERICK MEMORIAL	18,522	9.18%	21,926	9.93%	18,071	9.29%	21,085	10.03%
210006	HARFORD	4,704	11.59%	6,099	12.46%	4,308	9.94%	5,279	10.70%
210007	ST. JOSEPH	15,728	7.44%	18,865	7.90%	15,147	7.33%	18,144	7.88%
210008	MERCY	16,136	7.29%	20,266	8.91%	16,416	7.16%	19,146	7.95%
210009	JOHNS HOPKINS	34,989	10.93%	45,074	11.39%	35,425	10.90%	45,148	11.41%
210010	DORCHESTER GENERAL	2,799	10.15%	3,435	10.63%	2,401	10.00%	2,843	10.48%
210011	ST. AGNES	17,590	8.75%	21,223	9.28%	17,187	8.44%	20,603	8.76%
210012	SINAI	23,161	9.64%	27,822	10.10%	23,878	9.91%	28,821	10.38%
210013	BON SECOURS	6,148	11.99%	7,247	13.29%	5,716	11.70%	6,659	12.94%
210015	FRANKLIN SQUARE	20,097	9.81%	24,252	8.61%	20,580	8.95%	24,346	9.77%
210016	WASHINGTON ADVENTIST	13,910	7.56%	17,502	8.43%	12,967	7.84%	15,240	8.33%
210017	GARRETT COUNTY	2,154	6.78%	2,717	7.29%	2,024	5.78%	2,421	5.95%
210018	MONTGOMERY GENERAL	8,838	8.74%	10,518	9.60%	8,290	8.47%	9,793	9.04%
210019	PENINSULA GENERAL	19,554	9.74%	23,190	10.28%	18,316	9.24%	21,065	9.79%
210022	SUBURBAN	10,890	9.03%	14,140	8.93%	10,968	8.56%	13,735	8.59%
210023	ANNE ARUNDEL	24,804	7.00%	30,220	7.82%	26,867	6.98%	33,077	7.72%
210024	UNION MEMORIAL	11,940	10.03%	15,016	8.26%	12,019	9.64%	14,878	10.19%
210027	WESTERN MARYLAND	14,046	12.16%	16,497	12.77%	12,913	11.73%	14,713	12.43%
210028	ST. MARY	6,889	7.50%	8,963	10.47%	6,607	7.55%	8,578	10.43%
210029	HOPKINS BAYVIEW	18,278	9.44%	22,039	10.83%	18,233	8.56%	21,526	9.76%
210030	CHESTER RIVER	2,534	11.25%	2,973	12.01%	2,389	10.13%	2,798	10.79%
210032	UNION HOSPITAL OF CECIL	6,147	10.74%	7,618	11.21%	5,971	9.95%	6,978	10.48%
210033	CARROLL COUNTY	11,822	10.44%	15,440	11.28%	10,554	9.12%	13,103	9.96%
210034	HARBOR	9,953	7.73%	12,217	7.41%	9,459	7.74%	11,545	8.51%
210035	CIVISTA	7,158	9.07%	8,557	9.34%	6,634	8.77%	7,693	9.20%
210037	MEMORIAL AT EASTON	8,703	9.22%	10,398	9.70%	7,979	8.26%	9,332	8.94%
210038	MARYLAND GENERAL	9,024	10.89%	10,331	12.28%	7,970	9.44%	9,356	10.78%
210039	CALVERT	6,845	7.06%	8,463	7.99%	6,773	6.73%	8,192	7.42%
210040	NORTHWEST	10,849	13.00%	13,305	13.30%	11,175	12.56%	13,493	12.69%
210043	B.W.M.C.	15,397	11.07%	19,512	11.13%	15,766	10.61%	19,169	10.88%
210044	G.B.M.C.	20,765	6.05%	23,657	6.79%	19,593	5.38%	22,337	6.11%
210045	MCCREADY	435	6.67%	537	6.89%	315	6.35%	397	7.05%
210048	HOWARD COUNTY	16,715	7.16%	19,230	7.78%	16,663	6.82%	18,718	7.24%
210049	UPPER CHESAPEAKE	11,856	8.76%	15,365	9.39%	11,950	8.20%	14,671	8.92%
210051	DOCTORS COMMUNITY	9,999	11.56%	13,096	11.39%	9,744	10.21%	11,868	10.49%
210054	SOUTHERN MARYLAND	15,069	8.16%	18,446	9.08%	15,122	8.74%	17,919	9.48%
210055	LAUREL REGIONAL	5,732	7.24%	6,557	8.19%	5,787	7.05%	6,455	8.04%
210056	GOOD SAMARITAN	12,428	14.24%	15,223	12.19%	12,309	13.14%	14,854	13.83%
210057	SHADY GROVE	22,700	6.37%	26,388	7.02%	22,454	6.21%	26,075	6.90%
210058	KERNAN	2,616	6.00%	2,768	7.41%	2,808	6.05%	2,983	7.58%
210060	FT. WASHINGTON	2,179	6.52%	2,699	6.67%	1,762	7.49%	2,115	7.52%
210061	ATLANTIC GENERAL	2,870	9.97%	3,994	9.36%	2,536	8.79%	3,021	8.74%
STATE TOTAL		587,133	8.93%	714,366	9.51%	575,889	8.58%	685,477	9.27%

Figure 2. Inpatient 0-1 Day Stays as a Proportion of Total Cases (Excluding Newborns)

Hospital Name	Hospital ID	FY07	FY08	FY09	FY10	FY11	FY12	FY13*
MERITUS	210001	19.36%	19.51%	18.79%	18.60%	17.19%	14.89%	15.14%
UNIVERSITY OF MARYLAND	210002	30.63%	30.87%	29.96%	30.14%	29.93%	27.99%	26.32%
PRINCE GEORGE	210003	20.29%	23.62%	22.93%	21.10%	18.42%	15.70%	12.09%
HOLY CROSS	210004	15.24%	13.62%	18.50%	19.25%	18.56%	17.96%	17.16%
FREDERICK MEMORIAL	210005	19.82%	19.91%	16.67%	19.44%	18.90%	17.53%	16.76%
HARFORD	210006	24.40%	26.07%	29.35%	24.35%	22.84%	18.60%	19.75%
ST. JOSEPH	210007	26.12%	25.90%	27.86%	22.61%	20.02%	20.15%	19.73%
MERCY	210008	24.82%	25.72%	26.14%	27.74%	25.65%	19.34%	19.29%
JOHNS HOPKINS	210009	27.04%	24.92%	25.51%	24.06%	23.49%	22.99%	21.33%
DORCHESTER GENERAL	210010	22.33%	21.28%	18.29%	20.60%	18.65%	15.51%	15.03%
ST. AGNES	210011	25.79%	24.54%	24.85%	24.71%	19.42%	19.62%	18.85%
SINAI	210012	21.32%	22.04%	21.09%	19.47%	18.92%	19.44%	18.04%
BON SECOURS	210013	12.81%	14.31%	13.91%	14.14%	15.12%	14.55%	12.66%
FRANKLIN SQUARE	210015	30.49%	30.61%	32.17%	30.59%	20.21%	18.84%	19.16%
WASHINGTON ADVENTIST	210016	25.99%	23.96%	24.14%	24.33%	24.19%	18.08%	15.36%
GARRETT COUNTY	210017	27.34%	27.07%	29.53%	29.61%	24.59%	20.78%	19.94%
MONTGOMERY GENERAL	210018	19.49%	18.76%	17.72%	16.39%	17.55%	17.19%	17.81%
PENINSULA GENERAL	210019	19.10%	19.02%	18.51%	18.81%	17.94%	15.67%	15.43%
SUBURBAN	210022	26.64%	27.07%	25.77%	23.42%	22.99%	22.03%	17.28%
ANNE ARUNDEL	210023	25.26%	22.78%	24.39%	24.17%	23.89%	25.03%	23.49%
UNION MEMORIAL	210024	31.89%	30.84%	31.33%	32.55%	20.46%	19.49%	18.46%
*WESTERN MD	210027	21.49%	20.46%	20.99%	19.86%	16.41%	14.03%	18.90%
ST. MARY	210028	29.90%	31.04%	30.62%	35.49%	29.83%	29.57%	27.35%
HOPKINS BAYVIEW MED CTR	210029	23.34%	21.02%	19.51%	19.63%	19.19%	17.87%	18.03%
CHESTER RIVER	210030	16.24%	17.69%	21.80%	22.20%	16.33%	16.19%	14.17%
UNION OF CECIL COUNT	210032	25.17%	24.62%	27.24%	25.42%	22.09%	17.30%	17.89%
CARROLL COUNTY	210033	28.28%	26.75%	28.60%	30.77%	26.25%	23.92%	23.86%
HARBOR	210034	23.94%	21.96%	23.86%	25.06%	22.73%	22.37%	18.57%
CIVISTA	210035	22.54%	21.69%	24.99%	24.30%	19.93%	16.60%	18.13%
MEMORIAL AT EASTON	210037	24.43%	22.59%	20.18%	22.04%	19.51%	17.53%	17.52%
MARYLAND GENERAL	210038	12.49%	15.80%	17.91%	19.08%	14.29%	17.14%	14.12%
CALVERT	210039	23.78%	23.23%	30.23%	24.37%	22.89%	21.03%	20.65%
NORTHWEST	210040	20.91%	20.29%	20.48%	19.70%	18.73%	17.56%	17.42%
BALTIMORE WASHINGTON	210043	24.01%	23.56%	23.82%	25.07%	22.25%	19.24%	19.25%
G.B.M.C.	210044	22.69%	20.34%	20.92%	19.35%	16.58%	16.85%	16.92%
MCCREADY	210045	27.91%	25.96%	26.16%	27.39%	19.49%	20.75%	22.54%
HOWARD COUNTY	210048	19.61%	19.20%	19.42%	17.97%	17.36%	15.51%	15.10%
UPPER CHESAPEAKE HEALTH	210049	29.83%	32.98%	34.16%	29.10%	26.71%	22.15%	21.34%
DOCTORS COMMUNITY	210051	23.19%	22.57%	24.95%	25.54%	23.53%	18.27%	14.70%
LAUREL REGIONAL	210055	20.12%	19.86%	18.10%	18.00%	15.79%	13.54%	15.00%
GOOD SAMARITAN	210056	19.83%	19.89%	22.15%	22.46%	18.29%	17.71%	16.88%
SHADY GROVE	210057	21.43%	21.05%	19.96%	20.06%	19.57%	19.54%	20.03%
KERNAN	210058	6.32%	5.50%	5.95%	6.71%	5.49%	5.88%	4.89%
FORT WASHINGTON	210060	22.15%	20.00%	21.08%	21.15%	19.29%	16.79%	14.77%
ATLANTIC GENERAL	210061	23.19%	22.36%	22.63%	26.09%	28.25%	16.12%	17.61%
SOUTHERN MARYLAND	210062	24.21%	23.39%	23.01%	22.15%	21.44%	18.80%	17.84%
JOHNS HOPKINS - ONC.	210904	16.47%	18.14%	19.06%	17.73%	18.47%	16.73%	16.16%
TOTAL		**23.75%**	**23.36%**	**23.90%**	**23.39%**	**21.06%**	**19.52%**	**18.75%**

Source: HSCRC, April, 2013. Inpatient data. Note: Data prior to FY2011 combines 210025 and 210027. APR-DRG 560 and 640 were excluded from analysis(newborns). FY 2013 includes only data for quarter1 and 2.

The policy concern is that attaching APR-DRG rate capacity to short stays could encourage an expansion of these cases and reverse the progress previously made on reducing short stays in Maryland. Figure 2 demonstrates the reduction of short stay cases in Maryland. To the degree that these cases are denied as medically inappropriate, they would not generate rate capacity; but, the HSCRC staff believes that other mechanisms would be required to guarantee continued reductions on short stay cases. One possible solution is to monitor the number of short stays by hospital and adjust the hospital's revenue if predicted decreases in short stay cases fail to materialize without sufficient substantiation.

Hospice Cases

At its March 7, 2001 public meeting, the Commission approved a demonstration project allowing hospitals to provide general inpatient care to registered hospice patients at an agreed upon per diem amount to be paid to the hospital. The remaining balance between HSCRC approved rates and the per diem payment was required to be written-off by the hospital as a contractual allowance. These cases were removed from CPC logic through low trims. Due to a technical oversight, these hospice cases were not removed from the CPC/CPE beginning July 1, 2010 when the Commission excluded zero and one day stays from the CPC and, consequently, stopped calculating and removing low trims from our methodologies. Therefore, across several years, hospitals have gained excess rate capacity from demonstration project hospice cases. HSCRC staff has corrected this technical oversight by explicitly excluding these hospice cases from the CPC/CPE.

In the draft recommendation, HSCRC staff considered whether palliative care cases should be excluded from the CPC/CPE. Conceptually, a case entering an acute hospital with a palliative care order may be less resource intensive than a similar weighted case without the palliative care order. HSCRC staff investigated the impact of removing palliative care cases from the CPC/CPE.

On average, based on charges, palliative care cases use the same resources as non-palliative care cases on a case-mix adjusted basis, see Figure 3. In addition, HSCRC staff could not isolate cases that entered the hospital with a palliative care order from cases in which a physician ordered palliative care at some other point during the hospital stay. Hospitals code cases with a secondary diagnosis of palliative care, code V66.7, if at any time in the stay there is a palliative care order. The palliative care order could be written prior to admission or at any point during the hospital stay. V66.7 is POA except code, therefore, providing no additional information on the timing of the palliative care order.

Based on our review of palliative care cases, HSCRC staff recommends the Commission take no action regarding palliative care cases.

Recommendation: Reintroduce Short Stay Cases into the CPC/CPE

HSCRC staff recommends the Commission reincorporate short stay cases into the CPC/CPE and instruct the HSCRC staff to monitor the percentage of short stay cases in hospitals.

Figure 3. Comparison of Cases with and without ICD-9 code of V66.7

Hospital Name	HOSPID	FY2012							
		Cases with V66.7	Average LOS	Average Total Charges	CMI Adjusted CPC	Cases without V66.7	Average LOS	Average Total Charges	CMI Adjusted CPC
MERITUS	210001	371	7.49	$20,064	$13,053	17,117	4.09	$10,486	$11,791
UNIVERSITY OF MARYLAND	210002	304	12.55	$49,117	$19,216	37,734	5.74	$27,134	$20,271
PRINCE GEORGE	210003	17	7.35	$19,331	$9,130	13,511	4.90	$14,107	$15,524
HOLY CROSS	210004	454	10.34	$27,088	$14,846	35,659	3.66	$8,685	$11,804
FREDERICK MEMORIAL	210005	361	6.86	$17,267	$10,660	20,805	3.97	$9,469	$11,130
HARFORD	210006	72	8.14	$18,088	$11,664	5,235	4.22	$9,903	$11,989
ST. JOSEPH	210007	115	4.77	$13,133	$9,519	18,095	3.90	$12,270	$11,991
MERCY	210008	16	5.56	$16,652	$13,638	19,507	3.73	$12,047	$13,637
JOHNS HOPKINS	210009	469	12.81	$69,131	$26,263	42,810	5.63	$23,094	$19,538
DORCHESTER GENERAL	210010	57	5.12	$13,604	$10,877	2,793	3.97	$10,029	$13,099
ST. AGNES	210011	53	6.34	$15,736	$13,251	20,757	3.95	$12,416	$13,635
SINAI	210012	47	5.28	$24,201	$15,382	29,125	4.52	$15,038	$14,243
BON SECOURS	210013	40	7.50	$24,143	$14,931	6,670	4.36	$12,388	$13,600
FRANKLIN SQUARE	210015	332	5.74	$18,073	$11,945	24,199	4.10	$11,728	$13,696
WASHINGTON ADVENTIST	210016	59	9.17	$21,035	$13,397	15,261	4.61	$12,504	$13,628
GARRETT COUNTY	210017	23	5.26	$9,553	$10,697	2,430	3.25	$8,609	$11,555
MONTGOMERY GENERAL	210018	130	5.62	$13,182	$10,783	9,728	3.76	$9,741	$12,067
PENINSULA GENERAL	210019	435	7.37	$20,351	$13,117	20,793	4.10	$12,023	$11,762
SUBURBAN	210022	265	8.02	$18,114	$12,504	13,888	4.15	$12,971	$11,545
ANNE ARUNDEL	210023	316	6.21	$16,292	$12,176	32,840	3.51	$9,593	$11,842
UNION MEMORIAL	210024	312	6.91	$26,181	$15,264	14,633	4.08	$17,444	$14,357
WESTERN MARYLAND	210027	134	6.55	$15,903	$11,756	14,697	4.37	$11,852	$13,216
ST. MARY	210028	80	4.41	$11,551	$11,233	8,585	2.80	$8,015	$12,116
HOPKINS BAYVIEW	210029	90	9.39	$32,005	$14,805	22,212	4.50	$14,220	$15,454
CHESTER RIVER	210030	33	7.18	$18,599	$13,506	2,778	3.94	$10,717	$14,081
UNION OF CECIL COUNT	210032	144	3.28	$6,843	$8,826	6,893	3.55	$10,106	$12,595
CARROLL COUNTY	210033	99	3.94	$12,953	$11,079	13,279	3.23	$10,608	$13,137
HARBOR	210034	119	6.66	$20,763	$13,422	11,436	3.94	$12,186	$14,131
CIVISTA	210035	69	6.59	$14,755	$10,840	7,692	3.88	$9,238	$11,325
MEMORIAL AT EASTON	210037	228	5.76	$15,257	$12,058	9,116	3.66	$10,123	$12,414
MARYLAND GENERAL	210038	2	6.00	$24,240	$17,030	9,466	4.31	$13,244	$14,803
CALVERT	210039	20	3.95	$9,165	$7,965	8,279	3.16	$8,282	$11,321
NORTHWEST	210040	16	7.63	$18,587	$14,306	13,443	4.36	$10,790	$12,506
BALTIMORE WASHINGTON	210043	394	6.12	$14,634	$11,981	18,965	4.22	$11,854	$12,398
G.B.M.C.	210044	240	7.96	$21,031	$13,915	22,116	3.74	$10,063	$12,390
MCCREADY	210045	1	2.00	$4,643	$6,297	399	3.39	$13,085	$15,110
HOWARD COUNTY	210048	201	7.04	$15,804	$9,748	18,750	4.05	$8,953	$11,580
UPPER CHESAPEAKE	210049	247	5.85	$14,375	$10,152	14,533	3.40	$10,242	$11,366
DOCTORS COMMUNITY	210051	131	7.84	$18,230	$13,057	11,891	4.42	$11,533	$12,556
SOUTHERN MARYLAND	210054	146	7.42	$24,295	$12,830	17,705	3.72	$9,648	$12,215
LAUREL REGIONAL	210055	25	6.92	$12,729	$9,846	6,431	3.89	$9,403	$11,848
GOOD SAMARITAN	210056	99	6.20	$15,808	$10,627	14,886	4.72	$13,803	$12,813
SHADY GROVE	210057	109	9.78	$20,416	$13,452	26,028	3.90	$8,776	$11,836
ATLANTIC GENERAL	210061	96	5.68	$17,146	$11,447	2,931	3.97	$12,469	$11,265
JOHNS HOPKINS - ONC.	210904	251	10.25	$50,938	$18,248	4,813	7.34	$34,581	$18,300
STATE		7,222	7.65	$24,221	$14,808	698,987	4.27	$13,109	$14,104

Source: HSCRC, April 2013. Inpatient datasets for FY12. Note: Contracted hospice cases (Dailyser=10) excluded from analysis.

Appendix A
MHA Discussion Document

Maryland
Hospital Association

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

April 18, 2013

Nduka Udom
Associate Director, Research & Methodology
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215-2299

Dear Andy:

On behalf of the 66 members of the Maryland Hospital Association (MHA), we appreciate the opportunity to comment on the Health Services Cost Review Commission (HSCRC) recommendations on Modifications to the Admission-Readmission Revenue (ARR) Methodology presented at the April 10 public meeting. We appreciate the thoughtful consideration HSCRC staff has put into the recommendations to modify the ARR program. We understand modifications are being made for one year only and support many of the changes to the program for fiscal year 2014 as proposed by the HSCRC staff. We are concerned about the recommendation to cancel the ARR contracts and the level of shared savings with payors.

First, we'd like to highlight the recommendations we support. The proposed modifications to the ARR methodology maintain the alignment of clinical and financial incentives to reduce readmissions, unlike the Medicare readmissions payment policy which assesses penalties on hospitals with higher than expected readmission rates and does nothing to counter the disincentive and lost revenue as a result of readmission reductions. Successful readmission reduction strategies save Medicare and other payors not only through reductions in readmissions, but also as a result of fewer admissions, emergency department visits, and observation stays as a result of better care coordination and more engaged follow-up after discharge.

MHA supports the following points in the staff recommendation:

- Include one-day stays in the ARR program and the charge-per-episode weight calculations.
- Exclude planned readmissions following the algorithm used in the Medicare methodology. While excluding planned readmissions from the readmission count and considering them initial admissions adds complexity to a methodology that is already challenging to monitor, excluding planned readmissions increases the understanding and confidence in the methodology among clinicians.
- Set individual hospital targets for readmission reductions based on expected values and the prior calendar year's statewide performance. The methodology proposed to generate the 0.3 percent savings required by the Centers for Medicare & Medicaid Services (CMS) sets higher readmission reduction targets for hospitals that are not performing as well as expected. Calculation of statewide performance should include hospitals paid under the Total Patient

- more -

Appendix A
MHA Discussion Document

Revenue system. Although hospitals operating under a global budget may have inherent differences in readmission trends due to isolated geography, proximity to state borders, and a much stronger incentive to reduce readmissions, all hospitals have opportunities to reduce readmissions. As hospitals continue to reduce readmissions, this methodology will need to be revisited. At some point, most of the avoidable readmissions will be culled from the system and further reductions would harm patient outcomes.

- Exclude hospice cases using "service code 10" to identify hospice cases. Hospice cases services are fundamentally different from acute care and by contract, are paid at different rates. Best practice is to discharge from acute care and admit to hospice when a person's care transitions from acute care to hospice, a practice that makes these cases easily identifiable.
- Palliative care can be provided concurrently with curative care and should continue to be included in the charge-per-episode methodology.
- Set statewide trim points for each All Patient Refined Diagnostic Related Group and Severity of Illness cell. Statewide trim points effectively increase the charge level at which cases are classified as outliers and reduce the complexity of administering and monitoring the system. Hospitals with relatively low charge-per-case targets will benefit from a slight increase to those targets, and at the same time bear greater risk should they experience an increase in the number of outlier cases. For hospitals with the lowest charge targets, the increase in the outlier threshold represents a substantial risk should the number of outlier cases increase. This risk is compounded as inpatient volumes decline or remain flat. It takes many more included cases to break even on the additional outlier case. HSCRC staff has stated that after reviewing historical data, most low charge hospitals have been harmed by the hospital-specific trim point policy. We would request HSCRC staff share that analysis. Likewise, we would ask that the HSCRC retrospectively evaluate the move to statewide trim points one and two years after implementation.

Although we support many of the technical components of the recommendation, we have significant concerns with parts of the recommendations. HSCRC staff proposes to share between 0.3 percent and 0.5 percent of all-payor inpatient revenue with Medicare and other payors. Nationally, the Medicare program expects to save approximately 0.3 percent of Medicare base payments. Shared savings at the 0.3 percent level is a substantially greater amount in Maryland as it is a percentage of all inpatient revenue compared to national Medicare-only base payments, which do not include additional payments for medical education, disproportionate share, and other add-ons to Medicare Diagnosis Related Group payments. Readmission reduction targets should be set to generate no more than 0.3 percent of inpatient revenue savings across all payors.

The second and related concern is the recommendation to terminate all 31 three-year ARR contracts for the entire third year. The ARR contract states that the HSCRC can terminate the agreements for only one reason — "for cause." The HSCRC's stated "cause" for cancelling the contracts is a "strong indication" from CMS staff that in order to meet the "meet or exceed" requirement in the Affordable Care Act for Maryland's exemption from the Medicare readmission program, the HSCRC would have to add an explicit shared savings element to the existing ARR program. This would mark the second, and more onerous, change in the three-year agreement in the first two years of the agreements. MHA objects for practical and legal reasons.

- more -

Appendix A
MHA Discussion Document

As a practical matter, the Maryland agreements cover all readmissions, compared to the Medicare program which only looks at three diagnoses: acute myocardial infarction, heart failure, and pneumonia. The Maryland program's larger sweep requires more commitment and resources than does Medicare's, and the third year was always likely to be the year in which the greatest opportunity for improvement existed. Similarly, a program that focuses on reducing readmissions on all Medicare cases has the capability of producing significantly greater reductions than a program measured only by a limited number of diagnoses. Last, but certainly far from least, cancelling contracts so soon at the start of a significant program sends the worst possible message to hospitals at a time when co-operation is needed.

From a legal perspective, MHA does not believe the HSCRC has the right to walk away from its contractual obligations. Indeed, the recommendation would terminate the contracts altogether and replace them with a policy that compelled hospitals to meet the new requirements. Replacing contractual relationships with mandates sends a message too.

The HSCRC can contract, but it does not escape the laws of contract just because it is a governmental entity. In Maryland, terminating a contract for cause has generally required the non-cancelling party to have breached the contract in some way. *Bd of Street Com'rs of Hagerstown v. Williams*, 96 Md. 532 (1903); *Chai Management, Inc. v. Leibowitz*, 50 Md. App. 504 (1982). The stated cause, not any hospital failure, but the act of a governmental entity or change in law — Medicare indicated the current ARR program "may not meet the Affordable Care Act requirement for financial savings." This might justify cancelling the remainder of the contract if indeed Medicare's contemplated action was an unforeseen and unforeseeable event that was not, and could not have been, known to be a possible result when the contracts were signed under the legal impossibility or commercial frustration doctrines. That is not the case. The Affordable Care Act provision in question was enacted in March 2010, both requiring a readmission program that applied to Maryland hospitals and giving the Secretary of the Department of Health & Human Services the authority to grant Maryland a waiver. The ARR policy was adopted eight months later, and the contracts were not signed until July 2011. The timing confirms that the HSCRC knew, or should have known, what CMS' position might be. A party to a contract cannot be excused from performance because of an intervening act of government if the action was reasonably foreseeable. In this case it was all but certain. The HSCRC could have inserted a cancellation right referencing the known potential Medicare problem, but it did not. The 31 hospitals have the right to insist that their contracts be honored. Individual hospitals are left with a difficult choice — agreeing to cancellation of a contract at a time when they need to know HSCRC actions are fair and predictable, or risk greater uncertainty and disruption by possibly losing the exemption from the Medicare readmissions program.

I appreciate your consideration of our comments and would be happy to respond to any questions you may have about them. I can be reached at 410-379-6200.

Sincerely,

Traci La Valle

Traci La Valle, Vice President, Financial Policy & Advocacy

cc: Commissioners, HSCRC

Appendix B
Current and Proposed CPC/CPE Categorical Exclusions

CURRENT CATEGORICAL EXCLUSIONS:	PROPOSED CATEGORICAL EXCLUSIONS:
ILIZAROV Cases = Only at Sinai - Drs. Paley, Herzenberg, Conway & Standard • Any procedure - from 781 to 789 - Limb lengthening/shortening procedures • Operating Physician Numbers (ghost) = 000058 015343 726722 609489	*No modification*
SOLID ORGAN TRANSPLANTS APR DRGS = 001 or 002 or 003 or 006 or 440 (ANY PROCEDURE = 5280 OR 5282 OR 5283 OR ANY PROCEDURE = 5280 OR 5282 OR 5283 OR 4100 OR 4101 OR 4102 OR 4103 OR 4104 OR 4105 OR 4106 OR 4107 OR 4108 OR 375 (through 09/30/2003) 3751 (after 10/01/2003) Heart Transplantation 4109 OR 336 OR 3350 OR 3351 OR 3352 OR 5569 OR 5561 OR 5281 OR 5051 OR 5059)	*No modification*
Melodysplastic - Any Diagnosis = 2387 for Johns Hopkins Oncology Center	*No modification*
JH Bayview Burn Center (Type of Daily Service = 7)	*No modification*
JH Hospital Pediatric Burn Cases (Age < 18) - 3rd Degree Burns	*No modification*
JH Oncology Center and U of Maryland Cancer Center A. Transplant Cases (Reserve Flag = 1) B. Research Cases (Reserve Flag = 2) C. Hemotological Cases (Reserve Flag = 3) D. Transfer In Cases (Reserve Flag = 4)	*No modification*
Denied Admissions (provided as standalone submissions to the Commission quarterly)	*No modification*
Zero and one day stay (LOS less than 2)	**Remove this exclusion**
Contracted hospice cases (Type of Daily Service = 10)	**Originally excluded through low trim policy. Add this as an explicit exclusion.**

Chet Burrell
President and Chief Executive Officer

CareFirst BlueCross BlueShield
1501 S. Clinton Street, 17th Floor
Baltimore, MD 21224-5744
Tel: 410-605-2558
Fax: 410-781-7606
chet.burrell@carefirst.com

CareFirst BlueCross BlueShield

April 25, 2013

Health Services Cost Review Commission
4201 Patterson Avenue
Baltimore, Maryland 21215

Re: Draft Recommendation on Modifications to the Admission-Readmission Revenue (ARR) Methodology and the HSCRC Response to the Federal Sequestration Legislation

Dear Commissioners:

CareFirst is providing the following comments on the draft ARR policy (including the proposed changes in the outlier methodology) and on the question of how the HSCRC should respond to the Medicare rate cut that has resulted from the federal sequestration legislation.

We believe that the HSCRC's actions on these policy issues will substantially impact its ability to hold hospital payment increases within the constraints imposed by the existing per case Medicare waiver test and the more challenging per capita limitations that have been proposed in the waiver application to the Center for Medicare and Medicaid Innovations (CMMI).

The goals and objectives that are established in the application cannot be achieved without strong leadership by the HSCRC. We urge the HSCRC to begin the difficult task of starting the process of achieving the needed changes by acting on the ARR, outlier and sequestration policies.

A. The Draft ARR Recommendations

Maryland has one of the highest hospital readmission rates in the U.S. Its Medicare readmission rate has been found in recent years to be the highest of all states and the highest in the U.S. outside of the District of Columbia. While the majority of readmissions are unavoidable, many readmissions are preventable. These readmissions have the effect of reducing patient satisfaction, raising patient risks and increasing total health system costs. The reduction of unnecessary readmissions is a national priority that has been endorsed by MedPAC and implemented by CMS for the Medicare program outside of Maryland.

Currently, the HSCRC allows the thirty-one (31) hospitals that have elected to participate in its ARR program to keep all of the revenue associated with their prior level of readmissions by bundling both the charges associated with the initial admission and the readmissions into an overall "Charge Per Episode" (CPE) that is established on an APR DRG-specific basis for each hospital. This policy has two undesirable effects: first, it locks in the prior level of payments despite the fact that some portion of the prior revenue associated with readmissions was tied to preventable readmissions; and, second, it undermines Maryland's position on the current per case waiver test by promoting reductions in readmissions without any reduction in payments. The result of reducing the denominator (i.e., admissions) while maintaining the numerator (i.e., payments) is a higher payment per case and a lower Medicare waiver margin under the existing per case test.

The Accountable Care Act (ACA) requires Maryland to establish a readmissions reduction program that will "meet or exceed" the financial savings that would be generated by the federal policy that applies to Medicare hospital payments outside of this state. The federal readmissions program is narrower than the current HSCRC program (it applies to only three DRGs) but it is designed to generate savings equal to 0.3% of total Medicare inpatient payments to the hospitals that are covered by it. Therefore, the HSCRC must modify its existing ARR policy to yield savings equal to or in excess of those that would be produced by the federal program in order to maintain its exemption from the federal readmissions policy.

The HSCRC staff has proposed to revise the ARR policy in three ways: first, to move the existing voluntary ARR program to a compulsory standard policy for all hospitals by terminating the existing agreements; second, to impose a targeted level of readmissions savings on hospitals on a pro rata basis with adjustments to screen out planned (i.e., medically appropriate) readmissions and to exempt the Total Patient Revenue (TPR) hospitals from these savings requirements; and, third, to implement changes in the methodology that is used by the HSCRC to define "outlier" cases and associated charges.

We believe the proposed changes in the outlier methodology should be separated from the proposed ARR policy changes notwithstanding the fact that they were included by the HSCRC staff as part of the draft ARR recommendations that were presented on April 10, 2013. Given their inclusion in the draft ARR recommendations, we feel compelled to address them in these comments.

While the proposed cancellation of the existing voluntary ARR agreements raises concerns about the confidence the hospitals will have in the future regarding voluntary arrangements, we recognize the need to correct the inherent deficiencies of the existing ARR policy and to respond to the ACA's requirements. The ACA has imposed the readmission reduction requirement on the HSCRC. In addition, the existing ARR policy that is reflected in the voluntary agreements is flawed and demands changes for the reasons cited above. We will defer to the HSCRC's legal counsel regarding the legality of the proposed cancellation of the existing agreements but we certainly endorse the need for a broad revamping of the existing policy.

In general, we believe that the HSCRC staff's proposed use of a pro rata ARR methodology that will impose, at the start of the rate year, a predetermined level of readmissions savings in relation to the performance of the individual hospitals is appropriate. The proposed approach, which would compare each hospital's readmissions to the statewide average level of readmissions by

APR SOI cell (i.e., by type of case adjusted by case mix and severity level) is meritorious. The adjustment for "planned" readmissions is appropriate and the targeted savings approach gives a strong financial incentive to reduce unnecessary readmissions to the degree possible in order to offset the readmissions penalty in FY 2014 and in subsequent years. We believe that the penalties imposed should be adjusted in future years if the hospitals achieve levels of readmissions that approach appropriate levels.

In addition, we believe the HSCRC should develop a practical method to take into account the effects of differences in socioeconomic status and/or other factors (such as the presence of a secondary diagnosis of mental illness or substance abuse) that are outside of hospital control that significantly affect the level of preventable readmissions. We also believe that the HSCRC should move expeditiously to develop a unique patient identifier that will allow it to track readmissions across hospitals. It is especially imperative for the HSCRC to address the problems that continue to stymie the implementation of a unique patient ID in preparation for the per capita test that would accompany the new waiver arrangement. Finally, it is our understanding that the net level of admissions that flow into Maryland from other states (or out from Maryland to other states) has been relatively stable over time but the HSCRC will need to make efforts to track these flows more carefully under a per capita waiver system.

In its April 10, 2013 draft ARR recommendation, the HSCRC staff discussed but did not take a position on the matter of whether the targeted readmissions savings should be set at 0.3% or 0.5%. We strongly advocate the use of the 0.5% savings target because the level of Medicare readmissions in Maryland is high relative to the nation. We know from the experience of our own "Patient Centered Medical Home" (PCMH) program—which has now completed its second full year of operation throughout Maryland, the District of Columbia and Northern Virginia—that appropriate financial incentives can significantly reduce the level of inappropriate readmissions. Given these observations, we strongly urge the HSCRC to adopt a targeted savings level of 0.5% in the revised ARR policy.

B. Outlier Methodology

As noted above, the HSCRC staff included proposed changes to the existing outlier methodology as part of its proposed changes to the ARR policy. We believe that these recommendations are severable from the rest of the ARR policy recommendation; that the bases for and techniques and formulas used in the outlier proposal(s) that are being made by the staff need to be more clearly articulated; and that additional data and analyses are needed before the Commissioners can judge the merits or demerits of the proposed outlier methodology changes in an informed manner.

In particular, we believe that the proposed use of a statewide outlier threshold (rather than a hospital-specific threshold) that was included in the April 10 staff recommendation has the undesirable effect of shifting outlier protection away from hospitals with relatively low charges to hospitals with relatively high charges. This effect is readily confirmed by the fact that Figure 9 in the HSCRC staff's draft ARR recommendation would reduce the level of outlier charges by 29% on a statewide basis; virtually maintain the level of outlier charges at Johns Hopkins Hospital; and reduce outlier charges overall (i.e., for all hospitals except Johns Hopkins) by approximately 40%. We do not believe this shift of outlier protection to a single, large hospital is warranted on any logical or factual basis. The staff recommendation did not provide a rationale for it other than the desire to simplify the administration of the outlier policy. We do not believe that administrative simplification is a sufficient basis for a methodological change that would have these highly skewed policy and revenue impacts.

In addition to causing a major change in the baseline distribution of outlier revenue across hospitals, the HSCRC staff's outlier proposal would provide hospitals with additional opportunities to restructure their charges to generate much higher outlier charges in future years. These charges would be passed through as additional revenue and the hospitals could simultaneously offset their higher charges for outlier cases by lowering their charges for non-outlier cases. The effect of these charge adjustments would be to reduce the charges for the non-outlier cases and thereby create undercharges relative to the approved amounts for these cases. The hospitals would be permitted to raise their charges under the Charge Per Case (CPC) constraint that would apply to these cases. In combination, these types of actions would raise payments per case and hurt Maryland's position under the current per case test and under the proposed per capita test. The opportunities to generate additional revenue would be skewed in the direction of the high charge hospitals if a statewide outlier threshold is used because their cases would be more likely to surpass the outlier threshold.

We believe that the HSCRC could substantially fix the problems that we have identified in the proposed outlier policy, and achieve a substantial level of administrative simplification, by establishing a hospital-specific outlier threshold for high charge level hospitals; by using a statewide outlier threshold for the other hospitals; and by eliminating, the $100,000 "dead zone" limitation which has the obvious and undesirable effect of artificially identifying more cases as outliers at the relatively high charge hospitals.

Finally, recent Maryland legislation requires the HSCRC to obtain stakeholder input prior to the adoption of the policy and methodology changes under a new waiver arrangement. We believe the HSCRC should, in the course of this review process, invite and facilitate broad public discussion of all important issues. In regard to the outlier policy, this review process should do the following:

(1) address the question of whether outliers increase or decrease the financial incentives to hospitals to improve care, with special attention to the relative need (if any) for outlier protection in large, medium and small hospitals;

(2) examine the relative levels of adverse events (e.g., falls, nosocomial infections, etc.) across hospitals and the impacts of differing levels of such events on outliers at the particular hospitals; and

(3) consider the merits of imposing hospital-specific rate adjustments (both positive and negative) to drive reductions in the level of adverse events and to reward unusually good performance in this area.

C. The HSCRC Response to the Federal Sequestration Legislation

The federal Budget Control Act of 2011 included provisions that imposed an automatic sequestration (i.e., reduction) in federal payments for various federal programs, including Medicare, as a result of the failure of Congress to achieve targeted deficit reductions. The 2.0% payment reductions that have been imposed by sequestration apply to Medicare hospital payments in Maryland and elsewhere throughout the U.S.

The Maryland Hospital Association (MHA) and individual hospitals have argued that the HSCRC should act immediately to raise rates to fully exempt the hospitals from the impact of the sequestration legislation. The hospitals have argued for relief on three bases: (1) they have cited past actions by the HSCRC that fully offset the effects of federal sequestrations as relevant precedents; (2) they have described the declines they have recently experienced in operating profits; and (3) they have argued that it would be unfair to impose on them the payment reductions that would flow from sequestration when hospitals in other states have the opportunity to shift such payment reductions to other payers (i.e., private sector payers). The MHA and the hospitals have also argued that the HSCRC could raise rates now to offset the sequestration cuts on a temporary basis and re-visit the issue of whether or not to impose the sequester reductions (fully or partially) during the determination of the update factor for RY 2014 in its entirety or for the July through December 2013 "stub" period.

In their draft recommendations of April 10, 2013, the HSCRC staff advised the HSCRC that it should not take any action at this time to offset the effects of sequestration and should consider these effects in the determination of the update factor for all or part of RY 2014. We strongly endorse this HSCRC staff recommendation for the reasons we present below.

First, the HSCRC's past actions to fully pass through the effects of previous sequestrations took place during the mid and late 1980s when the waiver margin was substantially more robust than it is today. The margin was relatively high at that time because the HSCRC did an outstanding job of controlling overall and Medicare cost increases during its early years through 1992. Since 1992, the increases in hospital costs per admission in Maryland have substantially exceeded the national average rate of growth. Different circumstances require different actions. We do not believe that the cited historical actions establish precedents that should be followed at this time given the highly precarious waiver margin that is projected for June 2014.

Second, it is true that operating margins have recently declined but profits on regulated business are much higher than overall operating profits. The hospitals have identified physician subsidies as the primary cause of the difference between operating profits and regulated profits. The legality of the HSCRC's incorporation of the effects of physician subsidies on profits as a basis for higher rates is an unsettled and highly controversial proposition. It would certainly be inappropriate for the HSCRC to relieve the hospitals of the effects of sequestration without examining the levels of physician subsidies, the types of subsidies and their effects on overall hospital costs. This information is typically not disclosed by the hospitals.

Third, the ability of hospitals outside of Maryland to shift the effects of the sequestration payment cut of 2.0% is extremely limited in the short term because they cannot shift them to Medicaid; they cannot shift them, to any significant degree, to the large private health plans, which account for the bulk of private sector payments, because these plans pay for hospital care mostly in the form of fixed rates that cannot be raised prior to the termination of existing contracts; and they cannot shift them to the portion of patients who do not pay for their care. Thus, the argument that hospitals elsewhere can shift the effects of the sequester cuts is wholly unpersuasive as a basis for adjusting rates in Maryland in the remainder of FY 2013. Moreover, the ability of hospitals outside of Maryland to shift the sequestration cuts to the private sector in future years (i.e., beyond the short term) is also limited because many private health plans

have multi-year contracts with fixed rates and the widespread adoption of "high deductible health plans" (HDHPs) by small and large employers frequently causes bad debt levels to rise when hospitals increase their rates. As the HSCRC staff has suggested, the impact of the sequester cuts in FY 2014 can be considered as one of the myriad factors that should be discussed in the determination of the update factor for FY 2014.

Finally, the State of Maryland is currently involved in the extremely important task of attempting to negotiate a revised waiver arrangement for FY 2014. The HSCRC's existing one day stay policy (which encourages hospitals to reduce one day stays without imposing any revenue reductions) and its existing ARR policy (which encourages reductions in readmissions without any reductions in revenue) have the respective effects of thwarting the federal RAC policy (which takes revenue away from hospitals outside Maryland for excessive one day stays) and the federal readmissions reduction program (which imposes, on average, a 0.3% reduction in hospital inpatient payments). The willingness of CMMI to grant a new waiver to Maryland may be influenced by the extent to which Maryland demonstrates its determination to control Medicare and overall hospital payments.

Specifically, if Maryland overrides any portion of the sequestration savings that Medicare would obtain in the absence of the waiver, and shifts Medicare sequester cuts to the private sector, CMMI may question the credibility of Maryland's commitment to the "all payer" system that exists today and is proposed to continue under the waiver application.

D. Conclusion

In summary, we partially support the HSCRC staff's recommendation, dated April 10, 2013, regarding the ARR policy; and we wholly endorse the HSCRC staff's recommendation that the HSCRC should not adjust rates during FY 2013 in response to the federal sequestration cuts and that it should consider the effects of these cuts, among the many other relevant factors that merit attention, in the determination of the update factor for FY 2014.

Thank you for the opportunity to submit our comments on the proposed ARR and sequestration actions.

Sincerely,

Chet Burrell
President and CEO

Final Recommendations on Continued Financial Support for the Maryland Patient Safety Center for FY 2014

May 1, 2013

Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

This represents the recommedation as approved by the Commission on May 1, 2013.

Final Recommendations on Request for HSCRC Financial Support of the Maryland Patient Safety Center for FY 2014

Background

The 2001 General Assembly passed the "Patients' Safety Act of 2001," charging the Maryland Health Care Commission (MHCC), in consultation with the Department of Health and Mental Hygiene (DHMH), with studying the feasibility of developing a system for reducing the number of preventable adverse medical events in Maryland including, a system of reporting such incidences. The MHCC subsequently recommended the establishment of a Maryland Patient Safety Center (MPSC or Center) as one approach to improving patient safety in Maryland.

In 2003, the General Assembly endorsed this concept by including a provision in legislation to allow the MPSC to have medical review committee status, thereby making the proceedings, records, and files of the MPSC confidential and not discoverable or admissible as evidence in any civil action.

The operators of the MPSC were chosen through the State of Maryland's Request for Proposals (RFP) procurement process. At the request of MHCC, the two respondents to the RFP to operate the MPSC, the Maryland Hospital Association (MHA) and the Delmarva Foundation for Medical Care (Delmarva), agreed to collaborate in their efforts. The RFP was subsequently awarded jointly to the two organizations for a three-year period (January 2004 through December 2006). The RFP authorizes two one-year extensions beyond the first three years of the pilot project. MHCC extended the contract for two years ending December 31, 2009. The Center was subsequently re-designated by MHCC as the state's patient safety center for an additional five years – through 2014.

In 2004, the HSCRC adopted recommendations that made it a partner in the initiation of the MPSC by providing seed funding through hospital rates. The initial recommendations provided funding to cover 50% of the reasonable budgeted costs of the Center. The Commission receives a briefing and documentation annually on the progress of the MPSC in meeting its goals as well as an estimate of expected expenditures and revenues for the upcoming fiscal year. Based on these presentations, staff has evaluated the reasonableness of the budget items presented and made recommendations to the Commission.

Over the past 9 years, the rates of eight Maryland hospitals were increased by the following amounts, and funds have been transferred on a biannual basis (by October 31 and March 31 of each year):

- FY 2005 - $ 762,500
- FY 2006 - $ 963,100
- FY 2007 - $1,134,980
- FY 2008 - $1,134,110
- FY 2009 - $1,927,927
- FY 2010 - $1,636,325
- FY 2011 - $1,544,594

- FY 2012 - $1,314,433
- FY 2013 - $1,225,637

For FY 13, the Commission held in abeyance $100,000 of the requested funding pending MPSC development and submission to the Commission a feasibility study and options for relocating the MPSC to space outside of the existing Maryland Hospital Association complex in order to facilitate and encourage providers in addition to hospital providers to collaborate and participate in MPSC programs and activities. The study and proposed options were submitted the Commission on November 9, 2012; the study concluded that, based on the significant related expense, the MPSC should not move forward with the relocation.

In addition, the FY 2013 recommendation required that the Center investigate and take steps to improve standardization of data collection practices of participants in the various collaborative and learning network programs. MPSC indicated in its report on October 31, 2013 that it had begun and would continue to incorporate proactive site visits with participating facilities, create an audit tool for assessment of organizational compliance with data collection from staff interviews, documents review and observation.

The MPSC reports on its relocation feasibility study and data collection standardization work are in Appendix I.

Maryland Patient Safety Center Request to Extend HSCRC Funding

On March 28, 2013, the HSCRC received the attached request for continued financial support of the MPSC through rates in FY 2014 (Appendix II). The MPSC is requesting a total of $1,200,000 in funding support from HSCRC.

MPSC Cash Reserves

HSCRC staff was apprised at the March 28, 2013 meeting that the FY 13 and proposed FY 14 budgets as submitted do not include any allocation for the MPSC's cash reserves. HSCRC staff subsequently learned on April 9, 2013 that the MPSC is projected to have cash reserves of $946,390 approximately 148 days cash on hand as of June 30, 2013(Appendix II).

The MPSC indicates their Certified Public Accountant advised that average days cash on hand for similar organizations are 6 – 9 months. However, due to the high level of concentration risk from the HSCRC funding, and the conservative nature of the Board, the Board authorized setting the following amounts going forward for cash reserve:

1. 365 days cash on hand for operations.
2. $250k designated for unfunded initiatives that may arise.

Of particular concern is in the event that the HSCRC funding was not available, the Center would still be able to operate for a year while reorganizing the funding stream. The $250k figure is based on the cost of the prior unfunded initiative (Hand Hygiene) picked up by the Center.

The MPSC notes that these amounts are something the Center seeks to accomplish over a period of time through increased funding

Strategic Partnerships

The MPSC indicates it has established and continues to build new strategic partnerships with key organizations to achieve its mission and goals. The organizations with which they indicate they are working closely and anticipate continuing to do so for FY 2014 and beyond are described below.

- **Courtemanche & Associates -** An interdisciplinary healthcare firm that serves healthcare organizations to improve care through compliance with regulatory and accreditation requirements.
- **ECRI Institute** – A PSO and national vendor of adverse event reporting services.
- **Health Facilities Association of Maryland -** A leader and advocate for Maryland's long-term care provider community.
- **Institute for Patient -and Family- Centered Care –** A non-profit organization founded in 1992, which provides essential leadership to advance the understanding and practice of patient- and family-centered care.
- **Institute for Safe Medication Practices** – The leading national organization educating others about safe medication practices.
- **Maryland Healthcare Education Institute** – The educational affiliate of the Maryland Hospital Association.
- **Maryland Hospital Association** - The advocate for Maryland's hospitals, health systems, communities, and patients before legislative and regulatory bodies.
- **LifeSpan Network -** The largest senior care provider association in the Mid-Atlantic, representing more than 300 senior care provider organizations in Maryland and the District of Columbia.
- **The Ambulatory Surgery Center Association -** The national membership association that represents ambulatory surgery centers (ASCs) and provides advocacy and resources to assist ASCs in delivering high quality, cost-effective ambulatory surgery to the patients they serve.
- **Johns Hopkins School of Medicine / The Armstrong Institute for Patient Safety and Quality** – The patient safety center within Johns Hopkins Medicine.

Maryland Patient Safety Center 2013 Activities, Accomplishments, and Outcomes

Key highlights of the Center's accomplishments include:

- Developed and launched new data collection platform for Hand Hygiene Initiative
- Increased Hand Hygiene participation rate to 95% l
- Began process for improvement of data collection standards and integrity.

- Expanded outreach to other providers i.e., long term care, ambulatory surgical centers, primary care.
- Established partnership with Maryland Office of Health Care Quality to identify and address emerging patient safety issues
- Increased revenues from Annual Conference through registration fees and sponsorships.

The various initiatives the MPSC is currently engaged in are described below along with the results achieved to date.

MEDSAFE

Launched in 2000, MEDSAFE participants use the Institute for Safe Medication Practices (ISMP) Safety Self-Assessment® to assess the safety of medication practices within their organization. As reported in last year's recommendation, in 2012, 42 of 46 hospitals in Maryland completed the ISMP self-assessment survey. On a regular basis, aggregate results are analyzed and shared with hospitals to allow for statewide comparisons. Results from the survey, particularly improvement opportunities, are shared and discussed at the Annual MEDSAFE Conference. In 2012, the Conference had its largest level of participation to date with 220 healthcare professional attendees, including pharmacists, medication safety officers, nursing professionals and quality & safety leaders and addressed topics including:

- Using ISMP Self-Assessment Results for Medication Safety Improvements
- Improving Staff Education & Competency
- Using an Active Surveillance System as a Risk Identification Strategy
- Reducing Hospital Readmissions Related to Medication Use
- National Drug Shortages

SAFE from FALLS

The purpose of the SAFE from FALLS program is to reduce the incidence and severity of patient and resident falls in hospital, nursing home, and home health settings in Maryland. Launched in 2008, the SAFE from FALLS program includes hospitals, long term care facility and home health care provider participants. Each organization collects data on falls, education, and best practices for preventing falls. This is an important area for the MPSC to focus as:

- Falls are the second leading cause of unintentional injury deaths in the U.S.
- The incidence rates for falls in hospitals and nursing homes is almost three times the rate for persons living at home.
- Each year, 50% of hospitalized patients are at risk for falls and almost half of those who fall suffer an injury increasing costs and length of stay.
- The average hospital stay for patients who fall is 12.3 days longer and injuries from falls lead to a 61% increase in patient care costs.
- Falls are one of the largest categories of reported adverse events and are estimated to cost more than $20 billion a year nationally.

Key results from the SAFE from FALLS work include:

- Increased from 56 to 92 participant organizations (33 hospitals, 44 long term care, 15 home health).
- Acute care rate of falls trend is flat— approximately three per 1000 patient days. (9/09 – 12/12).
- Acute care rate of falls with injury trending downward—per 1000 patient days from 26 (9/09) to < 20 (12/12).
- Long term care trend—
    - trend increasing from just above four (4) (9/09) to six (6) (12/12)
    - rate with injury trending downward from approx. 22 to less than 20 (9/09 – 12/12)
- Home Health rate flat— at approximately 41 with similar results for rate with injury.

Appendix IV contains the figures illustrating the above trends.

Perinatal and Neonatal Learning Collaborative

The purpose of the perinatal and Neonatal Learning Collaborative is to reduce elective inductions and c-sections prior to 39 weeks without medical indication, improve neonatal outcomes, and standardize the discharge process for mothers and infants including the late pre-term infant. Table 1 below outlines the implementation and ongoing work timeline of what is now the Perinatal and Neonatal Learning Collaborative.

Key results of the Perinatal and Neonatal Learning Collaborative include:

- 30 hospital participants
- Induction rate >39 weeks without medical indication is trending downward from 0.7% to 0.3% for the period 10/10 – 10/12
- C Section rate >39 weeks without medical indication is trending downward from 2.4% to .09% for the period 10/10 – 10/12
-

Figures illustrating the above trends are in Appendix III.

Hand Hygiene Collaborative

The purpose of the Hand Hygiene Collaborative is to reduce preventable infections in Maryland through better hand hygiene. Key components of the program include use of unknown observers to record hand cleansing upon exit from or entry to patient rooms, and a requirement that 80% of the units of a participating hospital collect 30 observations each month. Participation for FY 2013 has risen to 44 of 46 hospitals, with an overall compliance rate of 88% of caregivers performing proper hand washing for the units in the hospitals that are participating.

The MPSC has established the following as their current or near term goals for the Hand Hygiene Collaborative:

- Facilitate continued and increased participation among hospitals and units – goal is to have statewide hospital participation in hand hygiene compliance.

- Distribute CEO-level "Infection Dashboards" – Hospital CEOs now receive a quarterly report that compares their hand hygiene compliance rate to the hospital's central line-associated blood stream infection rate. Next quarter, catheter-associated urinary tract infection data will be added as well.
- Implement enhancements to data collection tool – work will get underway to make the submission of data easier and to allow participants to access their own data on demand, and to see trend data over time.
- Support Department of Health and Mental Hygiene in a statewide public campaign on hand hygiene.

In addition to the goals articulated by the MPSC, HSCRC staff has urged MPSC staff to use other publically available infection rate data, such as the Maryland Hospital Acquired Conditions (MHAC) infection PPCs, to corroborate their findings, identify focus areas for improving the Collaborative, etc.

Adverse Event Reporting

The MPSC continues to use the ECRI adverse event reporting system and offers it to all hospitals in the state for self-reporting of adverse events. Hospitals may select a Patient Safety Organization of their choosing with whom they submit confidential adverse event data. Seven hospitals submitted their data to the MPSC ECRI system as of March 2012, but the Center indicated it anticipated a modest increase in participation in the coming year. As of the drafting of this document, the number of hospitals reporting to the ECRI was not reported by the MPSC to HSCRC.

Spreading Excellence through Educational Programming

Educational programs are designed to train leaders and practitioners in the health care industry and share strategies to improve patient safety and quality. These programs have focused on the following areas:

- Patient safety tools training including root cause analysis, and failure modes and effects analysis;
- Professional development programs;
- Process improvement including LEAN workshops and Six Sigma certification;
- TeamSTEPPS Train-the-trainer programs; and
- Sharing information on MedSAFE, hospital information technology, and patient falls.

These programs, particularly the LEAN and Six Sigma programs are designed to improve efficiency and reduce costs at hospitals and nursing homes. One facility has reported savings of up to $20,000 related to pharmacy inventory reductions, and annualized savings of up to $2.2 million due to reduced cases of missing or reordered medications.

In their FY 2013 budget request, the Center reported the numbers of hospital staff participating in these programs for 2012. Updated numbers on these trainings were not reported by MPSC to HSCRC as of the drafting of this document.

Key Program Activities for FY 2014

Conferences

The Annual Patient Safety Conference provides awareness, education and the exchange of best practice solutions. The annual MedSafe Conference concentrates on the prevention of medication errors with an emphasis on processes and technology.

Objectives of these conferences are to:

- Educate providers regarding pertinent patient safety / medication related issues
- Expand geographic and participant reach of the Center
- Increase participation levels
- Increase revenue generation
- Establish Center as recognized educational resource

The vendor MPSC will use to convene these conferences is the Maryland Healthcare Education Institute

Patient Safety Certification

The certification will utilize both traditional classroom instruction and practical application methodology; using the Patient Safety Officer (PSO) as the focal point. The certification would extend to both individuals and institutions.

Key objectives of this program are to:

- Identify and solve actual patient safety issues
- Engrain "culture of patient safety"
- Establish patient safety as an institutional focus
- Develop teamwork approach to solving patient safety issues
- Empower participating staff to be patient safety leaders
- Provide real and measurable impact

The vendor MPSC will use the help implement this program is Courtemanche & Associates.

Patient/Family Centered Care Integration

The Maryland Patient Safety Center recognizes that patient/family involvement is an integral part of patient safety and proposes to incorporate this concept into current and new programs.

•Objectives of this program are to:

- Integrate patient/family centered concepts into applicable Center programming
- Identify patient/family participation opportunities
- Establish patient/family involvement as a Center program priority
- Develop teamwork approach between patients/families and providers
- Establish outcome metrics

The vendor MPSC will use for this project is Institute for Patient – and Family- Centered Care.

Caring for the Healthcare Worker

The purpose of this initiative is to recognize those factors and their impact that affect a healthcare worker's ability to safely carry out their duties while offering solutions and actions that will significantly decrease their influence on patient safety. Key objectives for this program are to

- Reduce the number of harmful patient safety incidents
- Increase patient satisfaction scores
- Improve worker satisfaction
- Increase worker retention rates

The vendor MPSC will use for this program is the Johns Hopkins University School of Medicine / Armstrong Institute for Patient Safety and Quality.

Safety Initiatives

MPSC will continue its efforts in the three initiative areas it has worked on for several years.

- Falls Reduction & Prevention of Harm Support a coordinated communication and improvement campaign through the "SAFE from FALLS" program.
- Hand Hygiene Improvement Reduce hospital acquired infections through better hand hygiene compliance.
- Perinatal/Neonatal Learning Network Apply newly developed risk assessment tool for mother and babies to determine discharge referral needs; decreasing readmissions and improve health outcomes for mother and infant.

The Center will accomplish this work directly with consultative support from Maryland Hospital Association; of note, the Center has added two additional staff members including a program manager.

Budget and Funding Sources for FY 2013 and Proposed for FY 2014

In, FY 13, MPSC continued its efforts to work with its partners to secure program-specific funding, and estimates the amounts they will secure for FY 2014 as illustrated in Table 1. Staffing and fringe expenses proposed for 5 FTEs, which are allocated to the program areas in the expenses, total $669,050.

Table 1. Proposed Revenue and Expenses

REVENUE	FY 2014 Budget	FY 2013 Budget
Cash Contributions from MHA/Delmarva	200,000	400,000
Cash Contributions from Hospitals	300,000	300,000
HSCRC Funding	1,200,000	1,225,637
Education Session Revenue	150,000	203,600
Long-term care Revenue	50,000	100,000
Conference Registrations	240,000	140,000
Sponsorships	75,000	29,400
Grants/Contributions	160,000	250,000
Total Revenue	**2,375,000**	**2,648,637**

EXPENSES	FY 2014 MPSC	FY 2014 Consultants	FY 2014 Total	FY 2013 Budget
Administration	562,450		562,450	1,030,561
Outpatient Dialysis (previously committed)	75,000		75,000	75,000
Programs				
Education Sessions		189,000	189,000	298,000
Annual Patient Safety Conference		427,650	427,650	295,000
MEDSAFE Conference		52,850	52,850	38,500
Caring for HC	65,300	88,550	153,850	
Patient/Family Centered Care	59,400	16,150	75,550	
Safety Initiatives	215,550	165,000	380,550	986,577
Certification	129,600	327,200	456,800	
Total Expenses	**1,107,300**	**1,266,400**	**2,373,700**	**2,723,637**
Net Income (Loss)			**1,300**	**(75,000)**

Findings

As was noted in the FY 2013 recommendation, the All-Payer System has provided funding support for the Maryland Patient Safety Center during its initial nine years with the expectation that there would be both short-term and long-term reductions in hospital costs – particularly as a result of reduced mortality rates, lengths of stays, patient acuity, and malpractice insurance costs. However, the Center has provided limited evidence that the programs have resulted in cost savings, and only to the extent that these savings relate to individual programs and for limited periods of time. The Commission desires that the Center provide more information that would:

1. Show program outcomes on a longer term basis along with concomitant savings; and
2. Demonstrate the magnitude of the public's return on investment of funding support.

Staff continues to believe that the programs of the MPSC seem to be well conceived. MPSC has worked particularly hard at beginning to establish relationships with providers across the continuum of care in the past year.

As noted in last year's recommendation, staff again notes that there tends to be a general lack of coordination with other patient-safety related initiatives across the state. Staff believes there that should be a broader plan for patient safety in Maryland, and that the MPSC should take a lead in that plan. In addition, the statewide patient safety plan should be considered in the context of overall delivery system reform. Over the past year, MPSC has made efforts to better coordinate with State and other entities, such as the Department of Health and Mental Hygiene, Office of Health Care Quality, and the Maryland Health Quality and Cost Council, on State priorities. The roles of the various State entities involved with patient safety should be clearly defined.

Beginning in FY 2010, the Commission's recommendations stated that the percentage of MPSC's total should decline each year and in no year should the dollar amount be greater than the previous year. The intent was to reduce support gradually and to encourage the MPSC to aggressively pursue other sources of revenue (including from other provider groups that benefit from Center programs) to help support the Center into the future.

In FY 10, the percentage support was reduced to 45%; however, recognizing the difficulty of raising funds during tough economic times, the Commission retained the 45% contribution in FYs 11 and 12. Nonetheless, the Commission's amount of support has declined on a dollar basis in each of the past 4 years and is proposed to decrease in FY 14, however the percentage of the total budget proposed is just over 50%.

- FY 2009 - $1,927,927
- FY 2010 - $1,636,325 -15.1%
- FY 2011 - $1,544,594 - 5.6%
- FY 2012 - $1,314,433 -14.9%
- FY 2013 - $1,225, 637 -6.8%
- FY 2014 - $1,200,000

Prior to FY 2013, the Commission approved a reduction of Commission support by half of the budget carryover from the prior year; this policy made it difficult for the Center to build up a reasonable budgetary reserve and the Commission approved removing this requirement for FY 2013. As previously noted, the Center projects it will have $946,390 cash on hand as of June 30, 2013.

Final Staff Recommendations

In light of the information presented above, staff recommends the Commission consider the changes below to the MPSC funding support policy.

Staff Recommends:

1. **HSCRC provide funding support for the MPSC in FY 2014 through an increase in hospital rates in the amount of $1,200,000, a $25,637 reduction from FY 2013;**
2. **The MPSC establish and maintain cash reserves of 6 months;**
3. **The MPSC continue to aggressively pursue other sources of revenue, including from other provider groups that benefit from the programs of the Center, to help support the Center into the future;**
4. **MPSC staff continue to develop and conduct its activities to ensure standardization of self reported data collection as outlined in the body of this recommendation document and in the MPSC report on these activities contained in Appendix I;**
5. **As has been articulated in the last several FY's funding recommendations, staff recommends that as part of the FY 14 MPSC funding recommendation, staff consider the funding request on an annual basis. Funding support in the future should consider: (1) how well the MPSC initiatives fit into a broader statewide plan for patient safety; (2) whether new MPSC revenues should offset HSCRC funding support; (3) how much MPSC has in budgetary reserve; (4) information on patient safety outcomes and the public's return on investment (from HSCRC funding); and (5) how MPSC initiatives dovetail with the HSCRC's payment-related initiatives and priorities, and other relevant patient safety activities. Examples of other initiatives MPSC should consider as it conducts its work in the coming year include the Delmarva Foundation medication safety work and the HSCRC MHAC work;**
6. **Going forward, HSCRC decrease the dollar amount of support by a minimum of 10% per year. Staff notes the criteria outlined in recommendation 5 are intended to provide rationale for funding decreases greater than 10%, but not less, in subsequent years.**

6820 Deerpath Road
Elkridge, MD 21075

MARYLAND Patient Safety CENTER

410.540.9210 (Phone)
410.540.9139 (Fax)

November 9, 2012

Steve Ports
Principal Deputy Director
Maryland Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Mr. Ports:

Pursuant to the Final Recommendations on Continued Support of the Maryland Patient Safety Center dated May 2, 2012, specifically staff recommendation 4; please find enclosed the schedule of expenses related to the proposed relocation of the Maryland Patient Safety Center (MPSC).

The schedule was prepared by MPSC staff and the MPSC internal accounting staff and reviewed by an independent auditing firm.

Based on the significant expense, it is the recommendation of the MPSC management not to go forward with the relocation. This recommendation along with supporting documentation was presented to the MPSC Board and Executive Committee with both bodies concurring with management's recommendation.

The schedule and cover letter is also being sent to the Executive Director, Patrick Redmon and the Commission Chair, John Colmers.

Should you have any question or require clarification, please do not hesitate to contact me via telephone at 410.540.5076 or via email at rimoff@marylandpatientsafety.org.

Sincerely,

Robert H. Imhoff III
President & CEO

6820 Deerpath Road
Elkridge, MD 21075

MARYLAND Patient Safety CENTER

410.540.9210 (Phone)
410.540.9139 (Fax)

November 9, 2012

Per the request of the Health Services Cost Review Commission contained in the final recommendations from the meeting of May 2, 2012, a feasibility study was conducted by the staff of the Maryland Patient Safety Center (Center) regarding the proposed relocation of the Center's offices from the current location within the Maryland Hospital Association campus. The results of that study are contained in the attached schedule of expenses.

The Center enlisted the assistance of Mr. Richie Blue of Blue & Obrecht (a commercial real estate firm), Nicole Szarko, C.P.A. of McLean, Koehler, Sparks & Hammond (independent auditors) and the Center's internal accounting staff.

The rent costs reflected in the proceeding expense chart represent an average, combined rental rate of class A, B and C properties within the Columbia / Elkridge, MD area. The Center's internal accounting staff compiled a schedule of ongoing operating costs that would be impacted by said relocation. In addition, a "best estimate" of one-time costs (i.e. moving, furniture purchase) was developed through use of historical data and researching current market costs. The data figures (and corresponding assumptions) developed by the Center staff and internal accounting staff were then sent for review and approval by the Center's independent auditors.

The figures presented in the following schedule have been deemed reasonable after having gone through the review and approval process conducted by the independent auditing firm.

6820 Deerpath Road
Elkridge, MD 21075

MARYLAND Patient Safety CENTER

410.540.9210 (Phone)
410.540.9139 (Fax)

Relocation Expense Chart

	Projected	Current	Variance
Recurring Operating Costs			
Rent	$ 44,000	$ 23,300	$ (20,700)
Accounting/HR Admin	55,000	35,000	(20,000)
Insurance	12,000	7,500	(4,500)
Network/Internet/Web hosting	45,000	12,600	(32,400)
Office Supplies/Admin/Payroll	14,000	12,000	(2,000)
Duplication/binding	10,000	-	(10,000)
Utilities	7,500	-	(7,500)
Copier lease	4,500	-	(4,500)
Total Recurring Operating Costs	$ 192,000	$ 90,400	$ (101,600)
Single Event Cost			
Leasehold Improvements	50,000	-	(50,000)
Telephone equipment	2,500	-	(2,500)
Furniture	35,000	-	(35,000)
Moving	5,000	-	(5,000)
Contingency	15,000	-	(15,000)
Total Single Event Costs	$ 107,500	$ -	$ (107,500)
Total Recurring and Single Event Costs	$ 299,500	$ 90,400	$ (209,100)

Note:

- Projected rent expense includes $22 per sq. ft. @ 2,000 sq. ft. and represents an average/blended rate of class A, B and C properties in the Elkridge/Columbia area.

6820 Deerpath Road
Elkridge, MD 21075

MARYLAND Patient Safety CENTER

410.540.9210 (Phone)
410.540.9139 (Fax)

October 31, 2012

Mr. Steve Ports
Principal Deputy Director
Maryland Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Mr. Ports:

Pursuant to the Final Recommendations on Continued Support of the Maryland Patient Safety Center dated May 2, 2102, specifically staff recommendation 3; please find enclosed the report from the Maryland Patient Safety Center.

The report is also being sent to the Commission Chair, John Colmers and the Executive Director, Patrick Redmon.

Should you have any questions or require clarifications, please do not hesitate to contact me via telephone at 410.540.5076 or via email at rimhoff@marylandpatientsafety.org.

Sincerely,

Robert H. Imhoff III
President & CEO

Report to the Health Services Cost Review Commission

By the Maryland Patient Safety Center:

Collaborative Participation and Standardization of Data Collection

October 2012

Introduction

The Maryland Patient Safety Center (the Center) has been engaged in collaboratives and learning networks as a core strategy to achieve positive change and improvement in patient safety in the Maryland healthcare community since 2007, beginning with the Perinatal Collaborative. Since that time, the Perinatal Collaborative has joined forces with the Neonatal Collaborative (established in 2009) to become the Perinatal Neonatal Learning Network in 2011. Additionally, the Center engaged in the SAFE from FALLS Collaborative in 2008 and the Hand Hygiene Collaborative in 2010.

Maryland Patient Safety Center Collaboratives and Learning Networks Structural Similarities

While the topics of the collaboratives and learning networks differ, there are some structural similarities that support the standardization of the data collection and management issues across the collaboratives. It is important to note that all collaboratives and learning networks sponsored by the Center are voluntary in nature and use self-reported data by participants. First and foremost, all three collaboratives are managed by our contractor Delmarva Foundation, the CMS-designated quality improvement organization (QIO) for Maryland who oversees data management for each of the collaboratives. While the Maryland Patient Safety Center is the lead organization for all collaboratives and learning networks, the Center's staff works closely with Delmarva to manage the operations for each of these important initiatives, which includes management and oversight of critical functions such as definition of project requirements, strategic direction, data management (including analysis and reporting) and education. Second, each collaborative includes resource materials that define the scope of the work associated with the collaborative, metric definitions, data collection requirements, reporting forms and software. In addition, collaboratives have defined communication and education strategies, which typically include monthly data submission, quarterly calls/webinars, routine contact with team leads providing technical assistance (focused on barriers and interventions), site visits, list servs, web portals and at least one face-to-face meeting or reunion a year for each collaborative. All of these communication/education strategies reinforce standardization and provide an opportunity for feedback with participants about specifications met or not met within the collaboratives/learning networks. Many of the resources described, are available and accessible on the Maryland Patient Safety Center website.

Collaborative/Learning Network	Start Date	Structural Characteristics						Notes
		Roadmap/Toolkit	Monthly Outcomes Data	Process Measures	Quarterly Conference Calls & Webinars	Technical Assistance	Face-to-Face Meetings	
Perinatal Neonatal Learning Network	**2007**	√	√	√	√	√	√	• 2 Reunions per year
SAFE from FALLS Collaborative	**2008**	√	√	√	√	√	√	• 1 Falls Congress • Quarterly newsletter
Hand Hygiene Collaborative	**2010**	√	√	√	√	√	√	• 1 Face-to-Face Meeting

More specifically, there are unique attributes and processes in each individual collaborative that contribute to the quality and uniformity of the data collected and reported.

The Perinatal-Neonatal Learning Network – Participation and Data Standardization

The Perinatal-Neonatal Learning Network has the involvement of 29 hospital perinatal teams and 24 neonatal teams. The Center is engaged in an effort to recruit all hospitals providing obstetric care in Maryland. During the first quarter of FY13, the program Co-chairs, Ann Burke, MD and James Rost, MD, and the Center are engaged in a process to achieve 100 percent participation of Maryland hospitals. This will be accomplished through letters of invitation, conference calls, and site visits to the four hospitals currently not participating in the program.

Also in FY13, the Learning Network has expanded its focus to: *standardization of the discharge process for mothers and infants including the late pre-term infant.* The initiative collects data on two process measures and one outcome measure:

1. (Process) The percentage of maternal and neonatal discharges where review of the clinical record of the mother and the baby reflect that a risk assessment was completed. Hospitals will review a random sample of records for each population and audit the records to assess whether risk factors were identified.
2. (Process) The percentage of records where risk was demonstrated AND there is a referral to a community provider or health department.
3. (Outcome) The percentage of patients who were determined to have risk factors, for whom referral was completed AND who kept the scheduled appointment. In order to maintain patient confidentially, this will be assessed by hospital staff that will make follow-up calls to the patient.

Hospitals have received training on collection of discharge data use of standardized audit tools for mother and baby, randomization of charts, data entry into specialized spreadsheets for mother and baby, and submission of data into the Perinatal-Neonatal portal. All information published at the project level is aggregated. The data collection methodology incorporates collection of maternal race (by US 2010 Census category) and maternal zip code. This permits examination of results broken out by disparities in race, and other demographic factors (income, educational level, etc.) captured in data describing the population in Maryland linked to the home zip code.

The Learning Network continues a focus and collects data on inductions and C-sections less than 39 weeks. To ensure uniformity, and reduce variation in the data captured, the Learning Network establishes values, in this case 26 hospitals in the "N" each reporting period. The first face-to-face meeting (reunion) for FY13 will be held in December 2012 and there will be time built into the agenda for the teams to interact with each other sharing ideas and operational details about how they are testing and implementing the requirements at their institutions. "Roundtable" sharing has been one of the most valued parts of the face-to-face sessions.

SAFE from FALLS Collaborative – Participation and Data Standardization

The SAFE from FALLS Collaborative has expanded in FY13 with 34 hospitals (3 hospitals were added); 45 nursing homes (19 nursing homes were added) and 16 home care organizations (7 facilities were added). The Center is engaged in an effort to recruit all 46 hospitals in Maryland to participate in the Collaborative. Consistent and frequent communications to stakeholders and providers is essential to recruitment. On behalf of MPSC, Delmarva has initiated coordinated communications and outreach efforts for the SAFE from FALLS program. In FY13, MPSC is working

with our partners and stakeholder groups at MHA, LifeSpan, HFAM and the Maryland QIO to assist program staff in achieving 100 percent participation for Maryland hospitals and 50 percent of the Maryland Long Term Care (LTC) providers. As there are more LTC facilities than our initial goal, we will continue to have "open enrollment" for LTC providers at a less intensive effort throughout the project year.

The foundation of the Collaborative is the SAFE from FALLS Roadmap and Toolkit which provides key definitions, infrastructure and specific actions for a comprehensive falls management program. The Roadmap and Toolkit were created by the Minnesota Hospital Association and have a proven track record of reducing falls among their member hospitals. The SAFE from FALLS Collaborative has also established a falls safety points incentive program aimed at increasing the number of facilities who enter data on a regular basis and to ultimately enhance the accuracy of the aggregate statewide reporting process.

SAFE from FALLS FY12 # of reporting facilities	Q1	Q2	Q3	Q4	AVG
Acute Care (hospitals)	30	23	26	29	27
Long Term Care	14	14	15	14	14
Home Care	5	6	7	6	6

The Maryland Hospital Hand Hygiene Collaborative – Participation and Data Standardization

The Maryland Hospital Hand Hygiene Collaborative expanded participation significantly in FY12 and now in FY13 there are 44 of 45 (97%) acute care hospitals engaged in the Collaborative. There is also one specialty hospital involved in the collaborative. Unlike the Perinatal Neonatal Learning Network and the SAFE from FALLS Collaborative, who have facilities reporting into a portal with software programming specifically created for the Maryland Patient Safety Center, the Hand Hygiene Collaborative uses the HandStats software program developed by Johns Hopkins. In October 2011, the Center signed a MOU with Johns Hopkins Health System to transition the data analysis from Hopkins to the Delmarva Foundation.

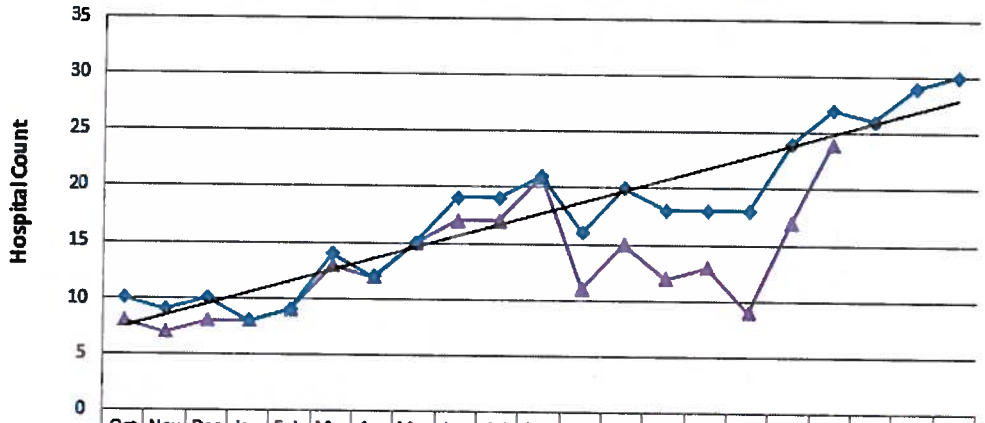
Initially, the Delmarva Foundation cleaned up the data in HandStats by verifying the data for required units and ensured consistency in reporting of the same required units each month. We found that this was not historically done within HandStats and that some hospitals had inconsistently reported data on required units and that the number of required units had changed over time. Delmarva verified the required units with each participating hospital and put a process in place to ensure that reporting was consistent from month to month for each hospital. This issue impacted the ability of some hospitals to meet the requirements of the project, specifically the 80/30 rule (80 percent of all required units must have 30 or more observations). Also, one of the more significant limitations of HandStats, was the fact that there was no "hard stop" on the system; therefore there was no way to lock users out of data entry after the deadline for data submission. Therefore, when discrepancies were reported by hospitals, there was no way to identify when data was entered into HandStats. These issues were addressed individually with hospitals and also on quarterly conference calls and webinars.

In February 2012, the Center provided hospitals with report cards that profiled their compliance with the 80/30 rule and their organization's performance compared to the statewide aggregate. With the initial distribution of report cards, and on an ongoing basis (monthly), we have asked hospitals to verify critical information such as the number of required units, required units with 30 or more observations, and their

hospital hand hygiene compliance rate. Reports of inconsistencies and discrepancies by hospitals were handled with technical assistance calls. Several hospitals raised some data discrepancies that could not be explained and as a result, several site visits were conducted in consultation with technical staff from Hopkins. At that time, the Maryland Patient Safety Center did not have access to the HandStats software to perform data verification. As a result, MPSC requested access to HandStats, and it was provided in April 2012. Similar access was granted to Delmarva in June 2012. Through the site visits, it was determined that HandStats was not counting observations entered on the last day of the month – defined as a "bracketing" issue by the analyst at Hopkins. Hopkins personnel adjusted the logic to the software on April17, 2012, which would take care of observations going forward but required reprocessing of past data. The Delmarva Foundation adjusted data back to October 2010, which resulted in changes to the number of hospitals meeting the 80/30 rule – see table below. Corrected data reflects a steady increase of hospitals achieving the 80/30 rule over time – from a low of 8 hospitals in the "N" to a high of 30.

Overall, the fluctuations in the number of hospitals meeting the 80/30 rule can be attributed to the technical difficulties and limitation of the HandStats platform and the barriers associated with having limited access to the software program, which prevented understanding and detection of key issues on the part of hospitals. Ultimately, when appropriate access to the HandStats software was provided to the Center and then Delmarva, we became more informed and were able to troubleshoot and work more closely with our hospitals to achieve the performance requirements with the Collaborative.

Original vs. Corrected
Number of Hospitals Meeting the 80/30 Rule



	Oct 10	Nov 10	Dec 10	Jan 11	Feb 11	Mar 11	Apr 11	May 11	Jun 11	Jul 11	Aug 11	Sep 11	Oct 11	Nov 11	Dec 11	Jan 12	Feb 12	Mar 12	Apr 12	May 12	Jun 12
Original	8	7	8	8	9	13	12	15	17	17	21	11	15	12	13	9	17	24			
Corrected	10	9	10	8	9	14	12	15	19	19	21	16	20	18	18	18	24	27	26	29	30

"new" hospitals represented 1, 1 and 4 respectively for April, May and June

The original 30 hospitals that have been participating in the Collaborative have been improving with an increasing number achieving the 80/30 rule, a direct result of several coaching calls and some one-on-one technical assistance. In March 2012, we began our focus on the additional 14 hospitals coming into the Collaborative and hosted an on-boarding call to gear them up for participation. Our goal was to bring hospitals into the Collaborative over the next few months, allowing them to become familiar with the specifications and requirements during that time and for them to be fully participating (achieving the 80/30 rule) with the submission of July 2012 data (the start of FY13). During the call we reviewed the specifications, provided guidance on the 80/30 rule, reviewed deadlines for data submission and

suggestions for entry of observations. Most importantly, we encouraged new hospitals to enter data routinely, and suggested a weekly data entry process, that would allow them to track and manage their observations more consistently. The second group of hospitals joining the Collaborative, had clearly benefitted from the lessons learned from the original hospitals participating in the Collaborative.

Delmarva is also checking the data in HandStats on a weekly basis to see if hospitals are entering more routine observations rather than waiting to the end of the month. If there is evidence that hospitals are not entering data on a regular basis, Delmarva will contact them to discuss their situation and advise them about recommended practices. This appears to be working as we have seen progress with these new hospitals over the past several months in their compliance (see chart below). The Maryland Hospital Association, a partner in this initiative, can also be credited with assistance with CEO engagement, by sending CEO's monthly participation summaries that were the focus of discussions between hospital leadership and infection prevention staff.

Month/Year	New Hospital Participants (14)					
	Met	%	Not Met	%	NDS*	%
7/2012	6	43%	6	43%	2	14%
8/2012	10	71%	4	29%	0	0
9/2012	12	86%	2	14%	0	0

Met – hospitals meeting 80/30 rule Not Met – hospitals not meeting the 80/30 rule NDS – No Data Submitted

Overall in calendar year 2011, we had approximately 16 hospitals on average meeting the 80/30 rule each month with a range from 8 - 18 hospitals meeting 80/30 each month. In calendar year 2012 (January – June), we have approximately 26 hospitals on average meeting the 80/30 rule with a range 18 - 30 hospitals meeting 80/30 each month. Weekly conference calls are held with staff from MPSC, Delmarva and MHA to discuss issues and track performance within the Collaborative and have been effective in determining which hospitals might need technical assistance and/or interventions.

Finally, the Center is in the final stages of developing a software application for Hand Hygiene that will replace HandStats. Not only are some of the issues that have been cited earlier a driver to developing our own software platform, but there are several others that have been raised by staff working with the Collaborative and requests from participating hospitals. Hospitals currently have limited capabilities to run historical data for their hospital; and hospitals must enter data manually (many hospital have limited or no administrative support staff within their Infection Prevention Departments to enter data) and do not have the ability to upload a flat file. Staff would like greater capabilities to manage data submitted; have the software manage some of the edits for consistency; and we feel that down the road, more in-depth analysis will be required to get us to the Collaborative's goal of 90 percent compliance. Before we move all hospitals to the new platform, we have planned a pilot test for the new software. We have selected five hospitals to test the software over the next several months, while maintaining hospitals entry into HandStats. This will allow us to test and make modifications, as needed, with a goal to "go live" with all hospitals in January 2013.

The data being reported for all Maryland Patient Safety Center collaboratives is collected voluntarily and is self reported. The Center has incorporated structural characteristics into each collaborative, in order to ensure a satisfactory level of consistency and standardization. Those actions include: project guidelines,

training, education, conference calls, webinars, site visits and regular meetings with our data management vendor (Delmarva Foundation).

Summary

While we feel that a solid footing has been established with regard to data standardization, we also recognize the need to improve and advance rather than to simply maintain the status quo for all Collaboratives. In that regard, we have created a more structured approach in order to ensure that all participants are following prescribed guidelines to include: data collection/reporting compliance and proper application of methodologies. MPSC will be incorporating pro-active site visits with our participating facilities and will create an audit tool for more robust assessment of organizational compliance via staff interviews, review of documents and observation. By improving the level of data standardization we will have an even higher degree of confidence in the reported data and in turn, a stronger vehicle for action and ongoing education.

Maryland Patient Safety Center FY 2014 Program Plan & Budget

Presented to the Health Services Cost Review Commission

March 2013

Maryland Patient Safety Center Board of Directors

Appendix II

- **Susan Glover**, Chair, SVP, Chief Quality Officer
  Adventist HealthCare
- **Stanton G. Ades**, SVP
  Professional Pharmacies Omnicare, Inc.
- **John Astle**, Senator, District 30 (D)
  Maryland State Senate
- **Mike Avotins**, SVP, Large Group Operations
  CareFirst, BlueCross, BlueShield
- **Carmela Coyle**, President & CEO
  Maryland Hospital Association
- **Joseph DeMattos, Jr.**, MA, President
  Health Facilities Association of Maryland
- **Eugene Friedman**, Corporate Counsel
  1st Mariner Bank
- **Chris Goeschel,** ScD, MPA, MPS, RN
  The Armstrong Institute for Patient Safety & Quality
- **Nancy Beth Grimm**, RN, JD
- **William Holman**, President & CEO
  Charles County Nursing & Rehabilitation Center
- **David Horrocks**, President
  CRISP
- **Robert Imhoff**, President & CEO
  Maryland Patient Safety Center
- **Heather R. Mizeur**, Delegate, District 20 (D)
  Maryland House of Delegates
- **Sherry Perkins**, PhD, RN, COO and CNO
  Anne Arundel Medical Center
- **Steve Ports**, Principal Deputy Director
  Health Services Cost Review Commission
- **Samuel Ross**, MD, CEO
  Bon Secours Baltimore Health
- **James R. Rost,** MD, Medical Director, NICU and Medical Director of Patient Safety
  Shady Grove Adventist Hospital
- **Steve Schenkel**, MD, Chair**,** Department of Emergency Medicine, Mercy Medical Center and Assistant Professor, Emergency Medicine, University of Maryland School of Medicine
- **Fredia S. Wadley**, MD, President & CEO
  Quality Health Strategies
- **Kathleen White**, PhD, RN, NEA-BC, FAAN, Associate Professor, Department of Acute and Chronic Care, The Johns Hopkins University School of Nursing

FY 2013 Highlights

Appendix II

- Developed and launched new data collection platform for Hand Hygiene Initiative
- Increased Hand Hygiene participation rate to 95%
- Began process for improvement of data collection standards and integrity
- Expanded outreach to other providers i.e., long term care, ambulatory surgical centers, primary care
- Established partnership with OHCQ to identify and address emerging patient safety issues
- Increased revenues from Annual Conference through registration fees and sponsorships

FY 2013 Initiatives Results

Appendix II

- **Hand Hygiene:**
  - Participation Rate of 95% (42 of 44 hospitals)
  - Overall compliance rate of 88% (January 2013)
- **Safe From Falls:**
  - 92 participants (33 hospitals, 44 LTC, 15 home health)
  - Acute care rate of falls per 1000 patient days flat at approximately three (3). (9/09 – 12/12)
  - Acute care rate of falls with injury (per 1000 patient days) trending downward from 26 (9/09) to < 20 (12/12)
  - LTC rate increasing from just above four (4) (9/09) to six (6) (12/12); rate with injury trending downward from approx. 22 to less than 20 (9/09 – 12/12)
  - Home Health rate flat at approx. 41 with similar results for rate with injury.

FY 2103 Initiatives Results (cont.)

Appendix II

- Perinatal / Neonatal:
  - 30 participants
  - Induction rate >39 weeks w/o medical indication trending downward from .7% to .3% for the period from 10/10 – 10/12
  - C Section rate >39 weeks w/o medical indication trending downward from 2.4% to .09% from 10/10 – 10/12

Strategic Partners

Appendix II

- **Courtemanche & Associates -** An interdisciplinary healthcare firm that serves healthcare organizations to improve care through compliance with regulatory and accreditation requirements.
- **ECRI Institute** – A PSO and national vendor of adverse event reporting services.
- **Health Facilities Association of Maryland -** A leader and advocate for Maryland's long-term care provider community.
- **Institute for Patient -and Family- Centered Care –** A non-profit organization founded in 1992, which provides essential leadership to advance the understanding and practice of patient- and family-centered care.
- **Institute for Safe Medication Practices** – The leading national organization educating others about safe medication practices.
- **Maryland Healthcare Education Institute** – The educational affiliate of the Maryland Hospital Association.
- **Maryland Hospital Association** - The advocate for Maryland's hospitals, health systems, communities, and patients before legislative and regulatory bodies.
- **LifeSpan Network -** The largest senior care provider association in the Mid-Atlantic, representing more than 300 senior care provider organizations in Maryland and the District of Columbia.
- **The Ambulatory Surgery Center Association -** The national membership association that represents ambulatory surgery centers (ASCs) and provides advocacy and resources to assist ASCs in delivering high quality, cost-effective ambulatory surgery to the patients they serve.
- **Johns Hopkins School of Medicine / The Armstrong Institute for Patient Safety and Quality** – The patient safety center within Johns Hopkins Medicine.

MARYLAND Patient Safety CENTER

FY14 Initiatives: Education Programs

Appendix II

- Educational programming according to needs of members & marketplace.
- Objectives:
  - Educate providers regarding pertinent patient safety/medication related issues
  - Expand geographic and participant reach of the Center
  - Increase participation levels
  - Increase revenue generation
  - Establish Center as recognized educational resource
- Vendor – Maryland Healthcare Education Institute

FY14 Initiatives: Conferences

Appendix II

- The Annual Patient Safety Conference provides awareness, education and the exchange of best practice solutions. The annual MedSafe Conference concentrates on the prevention of medication errors with an emphasis on processes and technology.
- Objectives:
  - Educate providers regarding pertinent patient safety / medication related issues
  - Expand geographic and participant reach of the Center
  - Increase participation levels
  - Increase revenue generation
  - Establish Center as recognized educational resource
- Vendor: Maryland Healthcare Education Institute

FY14 Initiatives: Patient Safety Certification

Appendix II

- The certification will utilize both traditional classroom instruction and practical application methodology; using the Patient Safety Officer (PSO) as the focal point. The certification would extend to both individuals and institutions.
- Objectives:
  - Ensure competency level of PSO
  - Identify and solve actual patient safety issues
  - Engrain “culture of patient safety”
  - Establish patient safety as an institutional focus
  - Develop teamwork approach to solving patient safety issues
  - Empower participating staff to be patient safety leaders
  - Provide real and measurable impact
- Vendor: Courtemanche & Associates

FY14 Initiatives: Patient/Family Centered Care Integration

Appendix II

- The Maryland Patient Safety Center recognizes that patient/family involvement is an integral part of patient safety and proposes to incorporate this concept into current and new programs.
- Objectives:
  - Integrate patient/family centered concepts into applicable Center programming
  - Identify patient/family participation opportunities
  - Establish patient/family involvement as a Center program priority
  - Develop teamwork approach between patients/families and providers
  - Establish outcome metrics
- Vendor: Institute for Patient – and Family- Centered Care

FY14 Initiatives: Caring for the Healthcare Worker

Appendix II

- The purpose of this initiative is to recognize those factors and their impact that affect a healthcare worker's ability to safely carry out their duties while offering solutions and actions that will significantly decrease their influence on patient safety.
- Objectives:
  - Reduce the number of harmful patient safety incidents
  - Increase patient satisfaction scores
  - Improve worker satisfaction
  - Increase worker retention rates
- Vendor: Johns Hopkins University School of Medicine / Armstrong Institute for Patient Safety and Quality

FY14 Initiatives: Safety Initiatives

Appendix II

- Falls Reduction & Prevention of Harm
  - Support a coordinated communication and improvement campaign through the "SAFE from FALLS" program.
- Hand Hygiene Improvement
  - Reduce hospital acquired infections through better hand hygiene compliance.
- Perinatal/Neonatal Learning Network
  - Apply newly developed risk assessment tool for mother and babies to determine discharge referral needs; decreasing readmissions and improve health outcomes for mother and infant

Maryland Patient Safety Center with consultative support from Maryland Hospital Association

Strategic Direction

Appendix II

- Development
- Expansion
- Looking toward the future
- Having greater overall impact on patient safety
- Increased oversight with creation of the Center Operations Steering Committee
- Improved coordination with statewide healthcare priorities:
  - HSCRC
  - OHCQ
  - Governor's Health Quality & Cost Council

MARYLAND Patient Safety CENTER

FY 2014 Budget

Appendix II

REVENUE	FY 2014 Budget	FY 2013 Budget
Cash Contributions from MHA/Delmarva	200,000	400,000
Cash Contributions from Hospitals	300,000	300,000
HSCRC Funding	1,200,000	1,225,637
Education Session Revenue	150,000	203,600
Long-term care Revenue	50,000	100,000
Conference Registrations	240,000	140,000
Sponsorships	75,000	29,400
Grants/Contributions	160,000	250,000
Total Revenue	**2,375,000**	**2,648,637**

EXPENSES	FY 2014 MPSC	FY 2014 Consultants	FY 2014 Total	FY 2013 Budget
Administration	562,450		562,450	1,030,561
Outpatient Dialysis (previously committed)	75,000		75,000	75,000
Programs				
Education Sessions		189,000	189,000	298,000
Annual Patient Safety Conference		427,650	427,650	295,000
MEDSAFE Conference		52,850	52,850	38,500
Caring for HC	65,300	88,550	153,850	
Patient/Family Centered Care	59,400	16,150	75,550	
Safety Initiatives	215,550	165,000	380,550	986,577
Certification	129,600	327,200	456,800	
Total Expenses	**1,107,300**	**1,266,400**	**2,373,700**	**2,723,637**
Net Income (Loss)			**1,300**	**(75,000)**

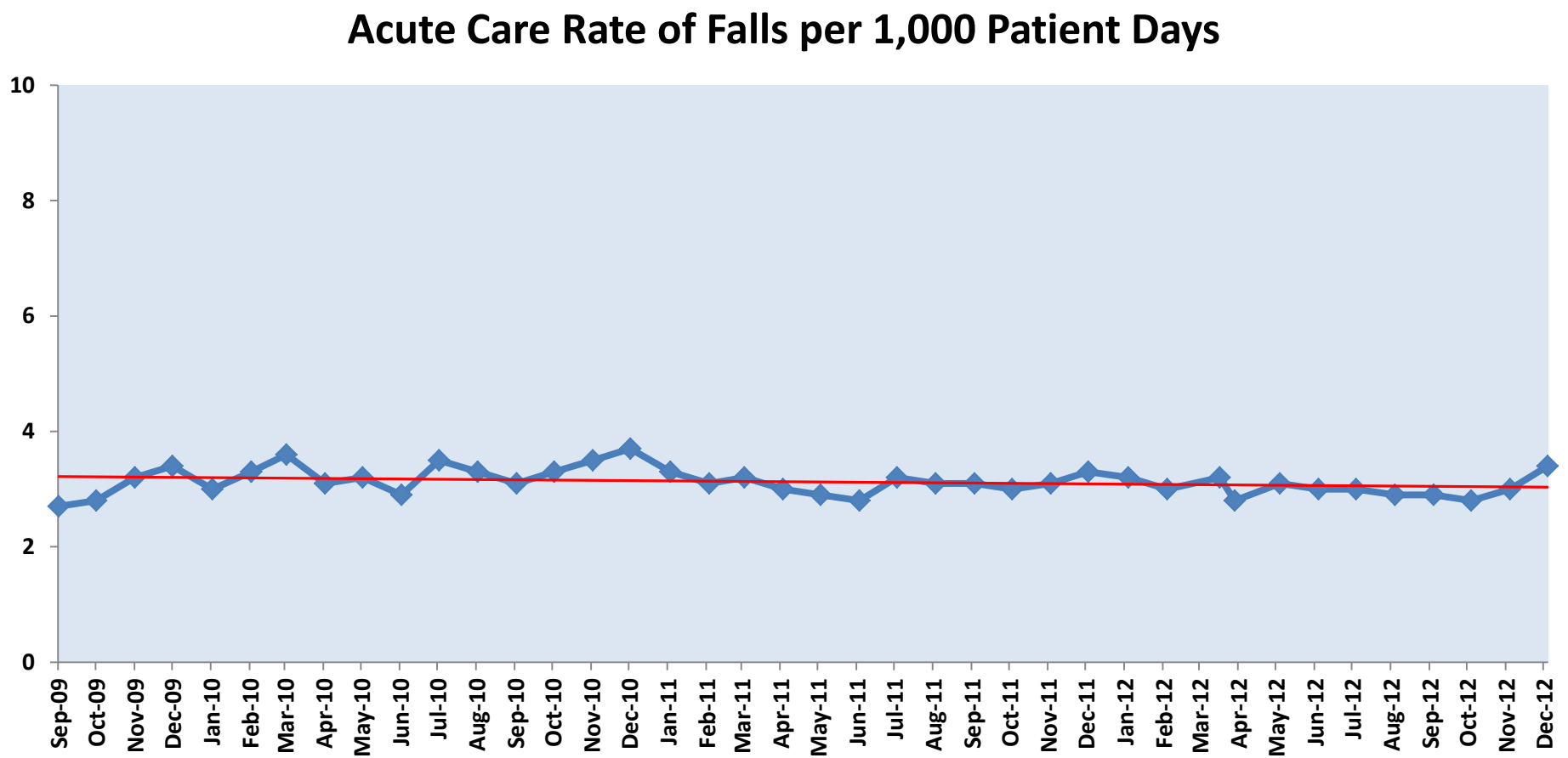
MARYLAND Patient Safety CENTER

Maryland Patient Safety Center, Inc.
Historical Reserves

	FY 2014 Budget	Projected 6/30/2013	6/30/2012	6/30/2011	6/30/2010	6/30/2009	6/30/2008
Total Operating Expenses	2,373,700	1,855,501	2,334,594	2,221,351	3,246,563	385,590	(33,962)
Unrestricted net assets	1,090,432	1,090,432	946,390	819,693	216,404	2,750,475	2,407,597
Days of Equity	168	215	148	135	24	2,604	(25,875)
Months of Equity	5.51	7.05	4.86	4.43	0.80	85.60	(850.69)

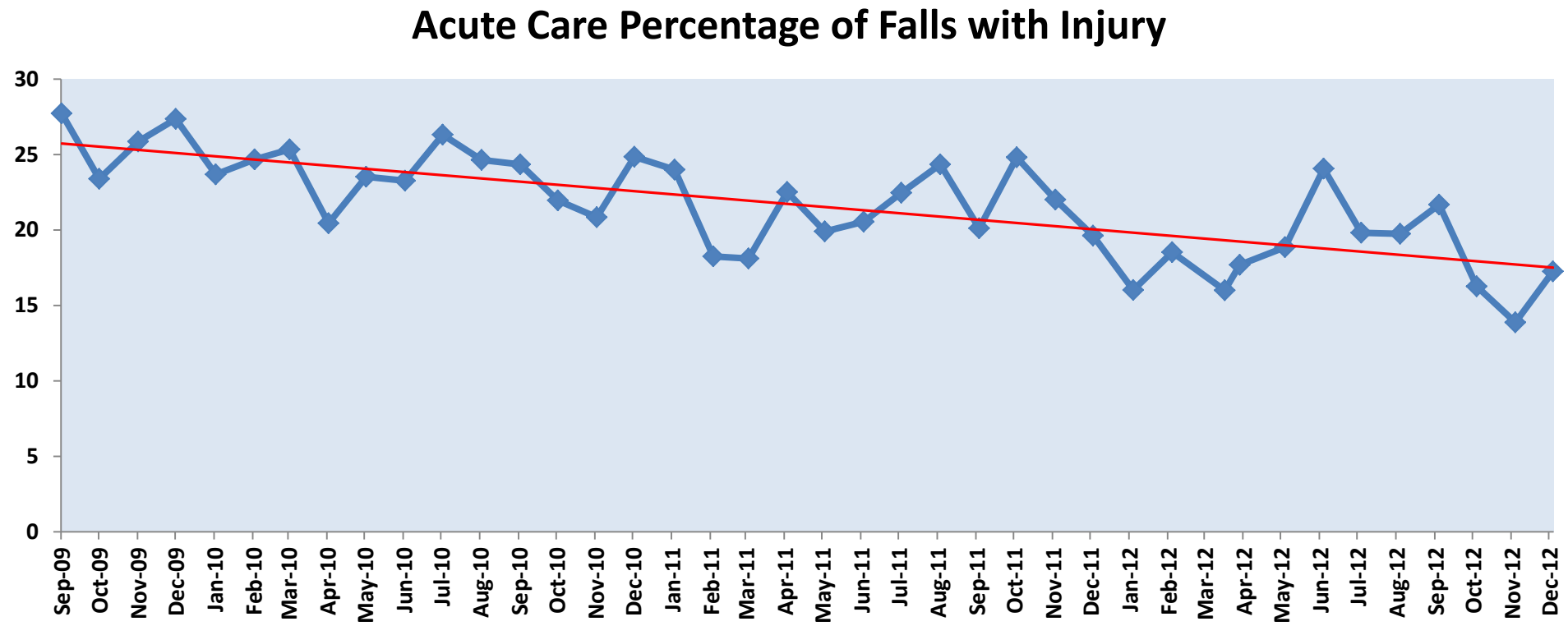
SAFE from FALLS – Acute Care

Appendix III



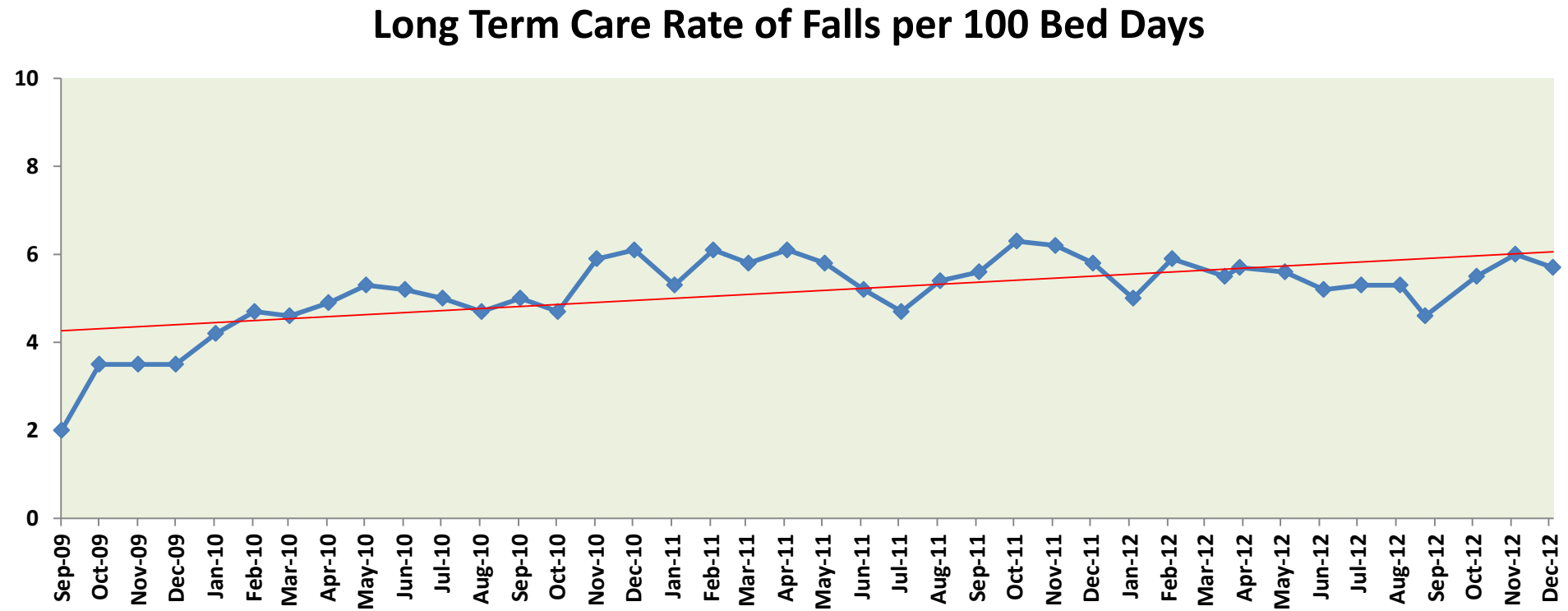
SAFE from FALLS – Acute Care

Appendix III



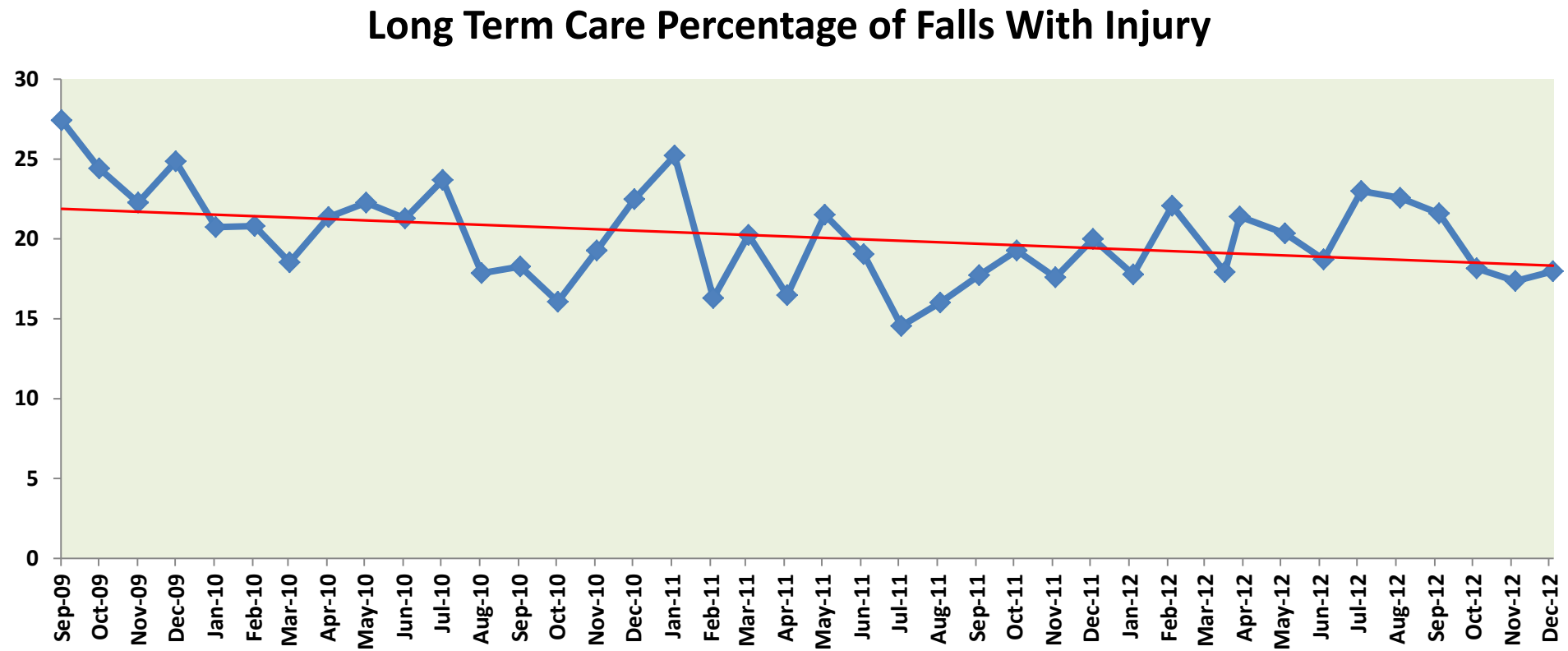
SAFE from FALLS – Long-Term Care

Appendix III



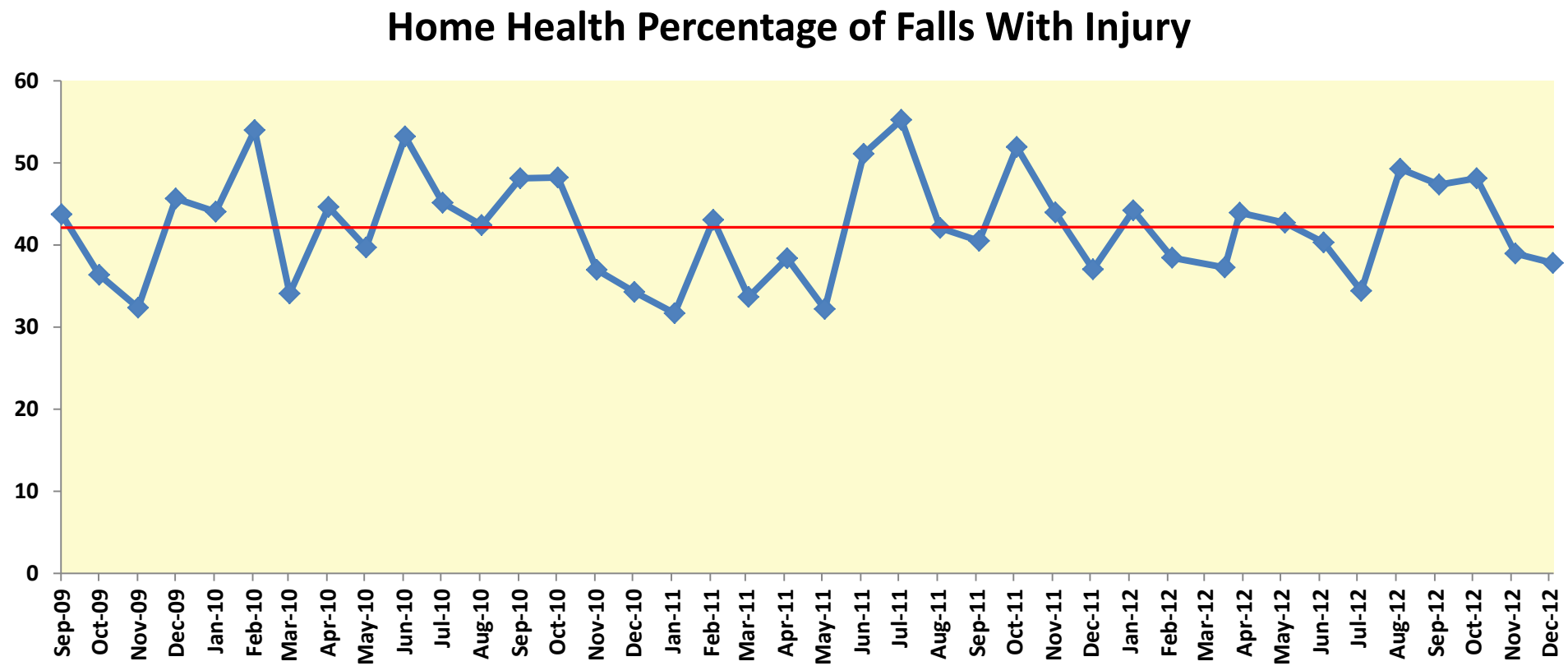
SAFE from FALLS – Long-Term Care

Appendix III



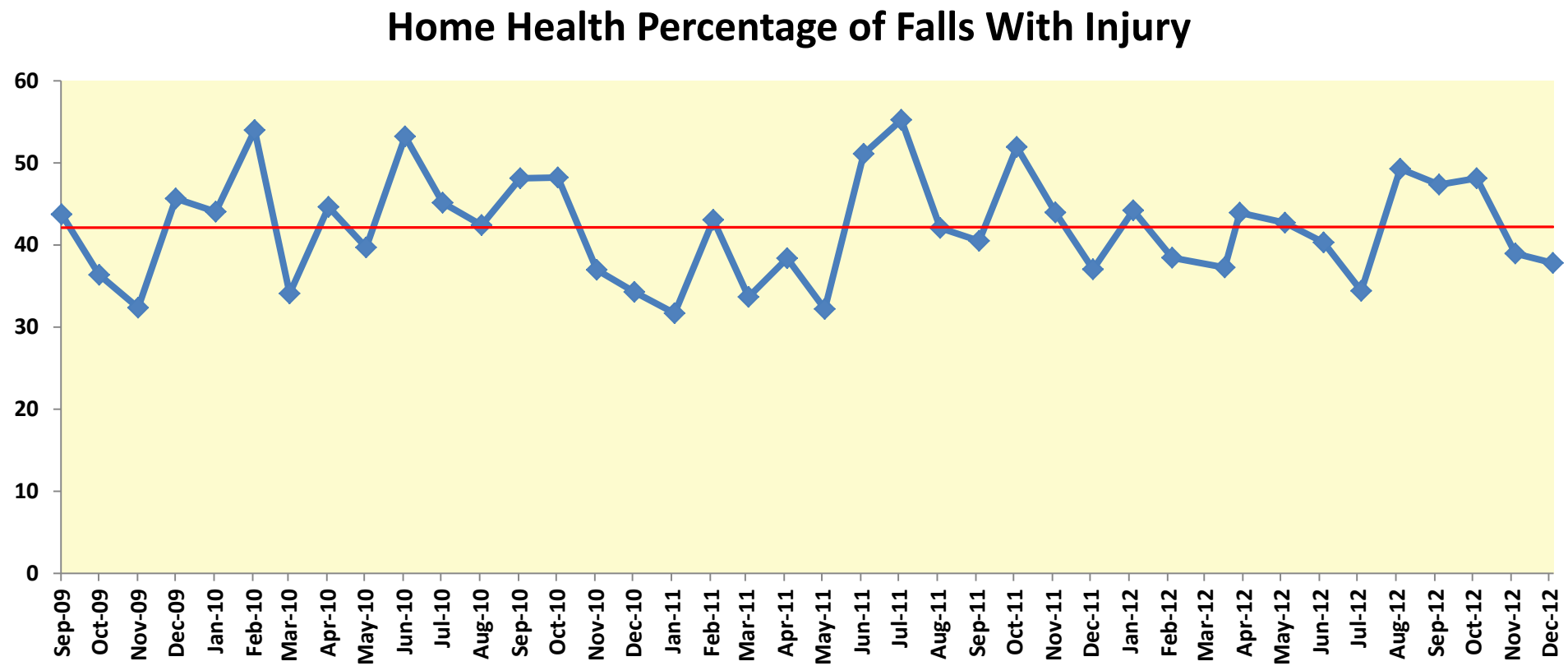
SAFE from FALLS – Home Health

Appendix III



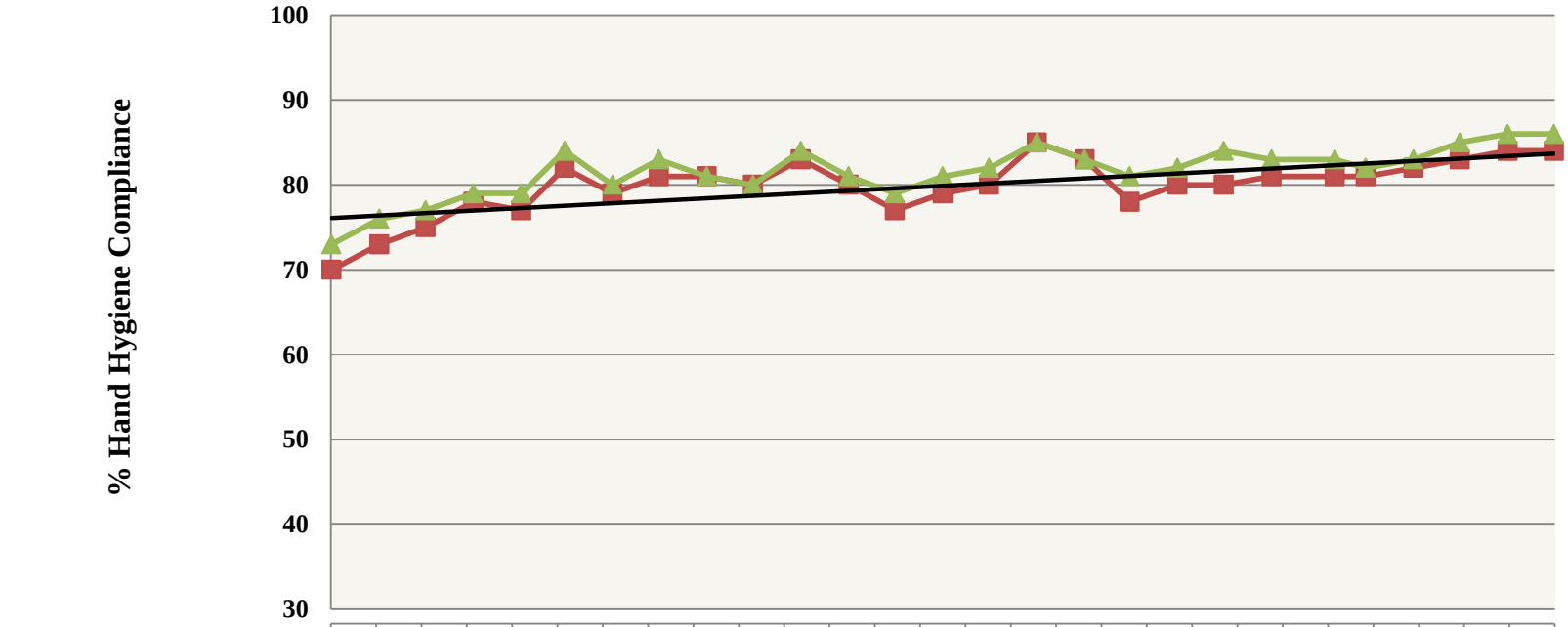
SAFE from FALLS – Home Health

Appendix III



Hand Hygiene

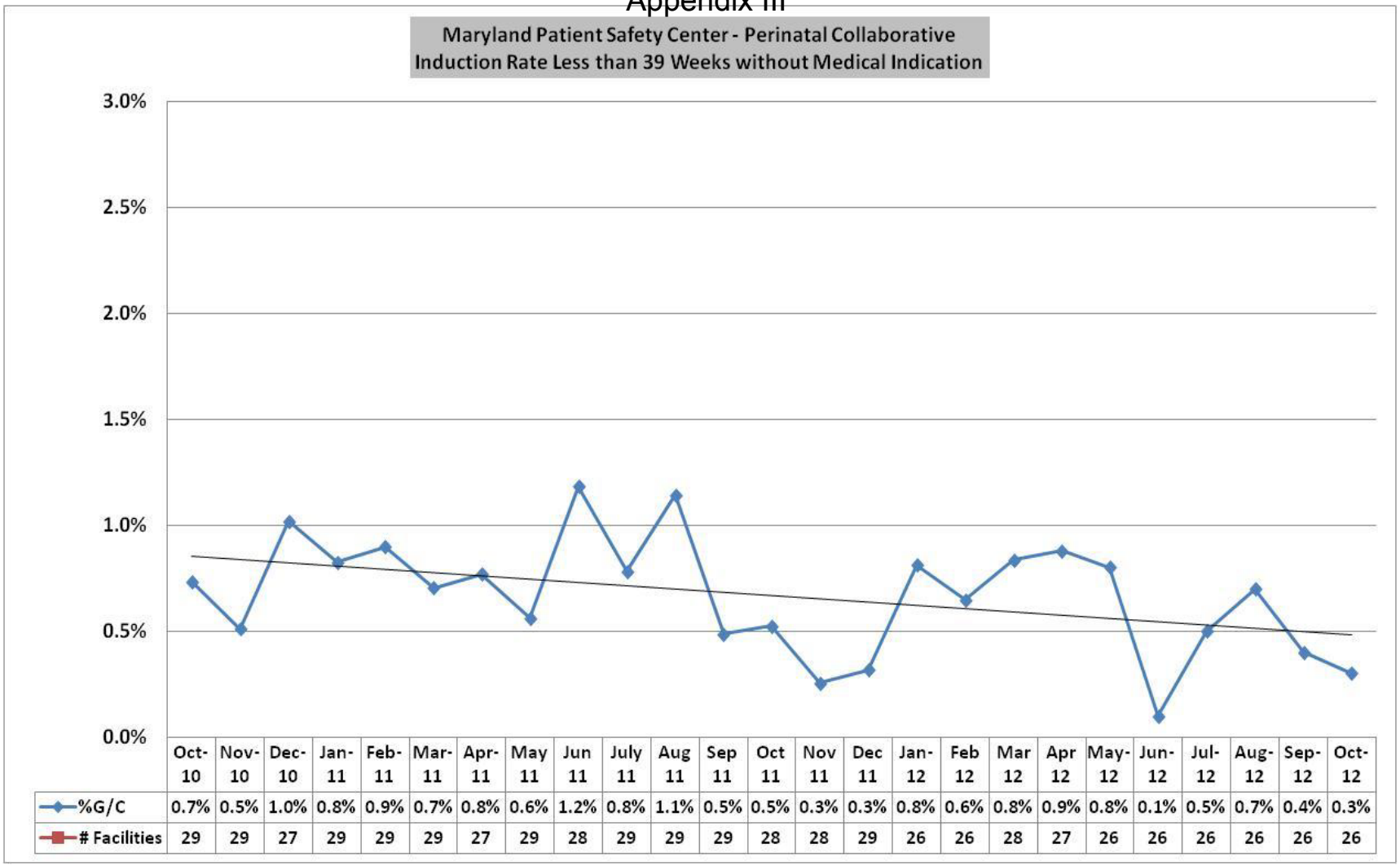
Appendix III



	Oct -10	Nov-10	Dec-10	Jan -11	Feb -11	Mar-11	Apr-11	May-11	Jun -11	Jul-11	Aug-11	Sep -11	Oct -11	Nov-11	Dec-11	Jan -12	Feb -12	Mar-12	Apr-12	May-12	Jun -12	Jul-12	Aug-12	Sep -12	Oct -12	Nov-12	Dec-12
Exit & Entry Compliance rate	70	73	75	78	77	82	79	81	81	80	83	80	77	79	80	85	83	78	80	80	81	81	81	82	83	84	84
Exit Only Compliance Rate	73	76	77	79	79	84	80	83	81	80	84	81	79	81	82	85	83	81	82	84	83	83	82	83	85	86	86

Perinatal/Neonatal Learning Network

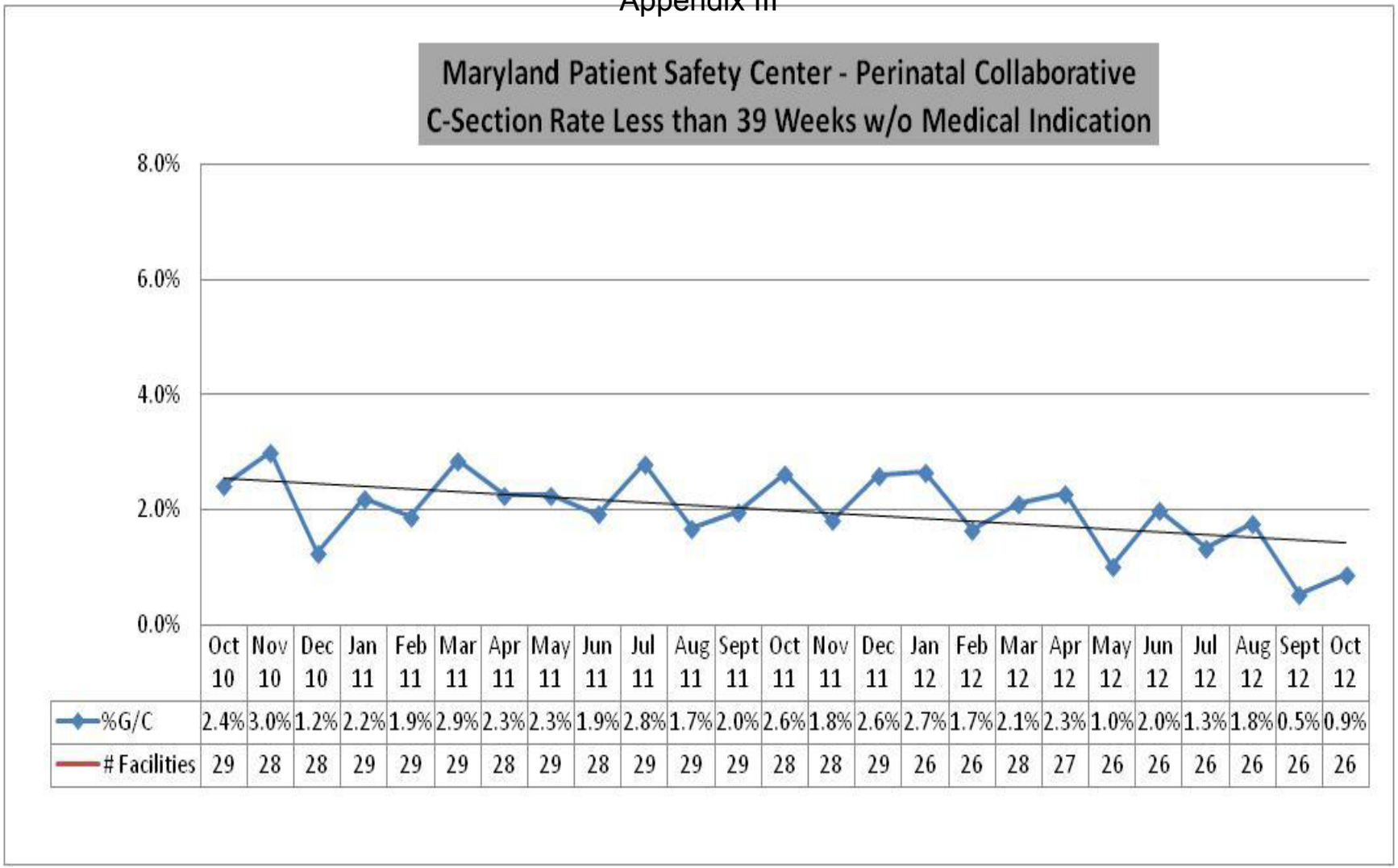
Appendix III



	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11	Apr-11	May 11	Jun 11	July 11	Aug 11	Sep 11	Oct 11	Nov 11	Dec 11	Jan-12	Feb 12	Mar 12	Apr 12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12
%G/C	0.7%	0.5%	1.0%	0.8%	0.9%	0.7%	0.8%	0.6%	1.2%	0.8%	1.1%	0.5%	0.5%	0.3%	0.3%	0.8%	0.6%	0.8%	0.9%	0.8%	0.1%	0.5%	0.7%	0.4%	0.3%
# Facilities	29	29	27	29	29	29	27	29	28	29	29	29	28	28	29	26	26	28	27	26	26	26	26	26	26

Perinatal/Neonatal Learning Network

Appendix III



	Oct 10	Nov 10	Dec 10	Jan 11	Feb 11	Mar 11	Apr 11	May 11	Jun 11	Jul 11	Aug 11	Sept 11	Oct 11	Nov 11	Dec 11	Jan 12	Feb 12	Mar 12	Apr 12	May 12	Jun 12	Jul 12	Aug 12	Sept 12	Oct 12
%G/C	2.4%	3.0%	1.2%	2.2%	1.9%	2.9%	2.3%	2.3%	1.9%	2.8%	1.7%	2.0%	2.6%	1.8%	2.6%	2.7%	1.7%	2.1%	2.3%	1.0%	2.0%	1.3%	1.8%	0.5%	0.9%
# Facilities	29	28	28	29	29	29	28	29	28	29	29	29	28	28	29	26	26	28	27	26	26	26	26	26	26

Staff Recommendation

May 1, 2013

The Commission staff recommends for final adoption revisions to the Relative Value Unit (RVU) Scale for Electrocardiography (EKG). The revisions are specific to the Chart of Accounts and Appendix D of the Accounting and Budget Manual. A work group comprised of experienced hospital and clinical personal was formed to address concerns regarding EKG. The workgroup decided to move Cardioversion, Automatic Implantable Cardioverter Defibrillator (AICD), and Tilt Table out of Interventional Radiology/Cardiovascular and into EKG, because these services are more diagnostic in nature and a better fit with other EKG services. The proposed changes were sent to all hospitals for comment. Comments were received; and all participants are in agreement with the proposed changes. The revised RVUs were approved April 9, 2013 by the Maryland Hospital Association's HSCRC Technical Issues Task Force. Hospitals will be required to calculate a conversion factor to assure no change in hospital revenue as a result of this revision. Hospitals will begin using these revised RVUs effective July 1, 2013.

This represents the recommendation as approved by the Commission on May 1, 2013.

7290 ELECTROCARDIOGRAPHY

Function

This cost center operates specialized equipment to (1) Record graphically electromotive variations in actions of the heart muscle; (2) Record graphically the direction and magnitude of the electrical forces of the heart's action, (3) Record graphically the sounds of the heart for diagnostic purposes; (4) Imaging; (5) Cardioversion; and/or (6) Tilt Table. Additional activities include, but are not limited to, the following:

> Explaining test procedures to patient; operating electrocardiograph equipment; inspecting, testing and maintaining special equipment; attaching and removing electrodes from patient; a patient may remove electrodes and remit recording data from home when appropriate.

Description

This cost center contains the direct expenses incurred in performing electrocardiographic examinations, as well as up to six hours of recovery time. Included as direct expenses are: salaries and wages, employee benefits, professional fees (non-physician), supplies, purchased services, other direct expenses and transfers. Cost of contrast material is included in this cost center.

Standard Unit of Measure: Maryland Relative Value Units

Data Source

The number of Relative Value Units shall be an actual count maintained by this cost center.

Reporting Schedule

Schedule D30

APPENDIX D
STANDARD UNIT OF MEASURE REFERENCES

Account Number	Cost	Center Title
7290	Electrocardiography	Service

The Electrocardiography Relative Value Units were developed by an industry task force under the auspices of the Maryland Hospital Association. These Relative Value Units will be used as the standard unit of measure related to the output of the Electrocardiography Center.

Electrocardiography (EKG) is a transthoracic interpretation of the electrical activity of the heart over a period of time. The EKG cost center operates specialized equipment to (1) Record graphically electromotive variations in actions of the heart muscle; (2) Record graphically the direction and magnitude of the electrical forces of the heart's action, (3) Record graphically the sounds of the heart for diagnostic purposes; (4) Imaging; (5) Cardioversion; and/or (6) Tiltable. Additional activities include, but are not limited to, the following:

> Explaining test procedures to patient; operating electrocardiograph equipment; inspecting, testing and maintaining special equipment; attaching and removing electrodes from patient; a patient may remove electrodes and remit recording data from home when appropriate.

Description

This cost center contains the direct expenses incurred in performing electrocardiographic examinations, as well as up to six hours of recovery time. Included as direct expenses are: salaries and wages, employee benefits, professional fees (non-physician), supplies, purchased services, other direct expenses and transfers. Cost of contrast material is included in this cost center.

Code	Description (CQ)	RVUs
92960	Cardioversion, elective, electrical conversion of arrhythmia; external	45
92960	Cardioversion in addition to TEE 5 RVUs. Also report TEE separately with 60 RVUs	5
93005	Electrocardiogram, routine ECG with at least 12 leads; tracing only, without interpretation and report	12
93017	Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; tracing only, without interpretation and report	30
93024	Ergonovine provocation test	30

93025	Microvolt T-wave alternans for assessment of ventricular arrhythmias	30
93041	Rhythm ECG, 1-3 leads; tracing only without interpretation and report	5
93225	Wearable electrocardiographic rhythm derived monitoring for 24 hours by continuous original waveform recording and storage, with visual superimposition scanning; recoding (includes connection, recording, and disconnection)	10
93226	Wearable electrocardiographic rhythm derived monitoring for 24 hours by continuous original waveform recording and storage, with visual superimposition scanning; scanning analysis with report	50
93270	Wearable patient activated electrocardiographic rhythm derived event recording with presymptom memory loop, 24-hour attended monitoring, per 30 day period of time; recording (includes connection, recording, and disconnection)	10
93278	Signal-averaged electrocardiography (SAECG), with or without ECG	30
93279	Programming device evaluation with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with physician analysis, review and report; single lead pacemaker system	15
93280	Programming device evaluation with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with physician analysis, review and report; dual lead pacemaker system	15
93281	Programming device evaluation with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with physician analysis, review and report; multiple lead pacemaker system	15
93282	Programming device evaluation with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with physician analysis, review and report; single lead implantable cardioverter-defibrillator system	20
93283	Programming device evaluation with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with physician analysis, review and report; dual lead implantable cardioverter-defibrillator system	20
93284	Programming device evaluation with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with physician analysis, review and report; multiple lead implantable cardioverter-defibrillator system	20
93285	Programming device evaluation with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with physician analysis, review and report; implantable loop recorder system	20

93286	Peri-procedural device evaluation (in person) and programming of device system parameters before or after a surgery, procedure, or test with analysis, review and report by a physician or other qualified health care professional; single, dual, or multiple lead pacemaker system	15
93287	Single, dual or multiple lead implantable cardioverter-defibrillator system	15
93288	Interrogation device evaluation (in person) with physician analysis, review, and report, includes connection, recording and disconnection per patient encounter; single, dual, or multiple lead pacemaker system	15
93289	Interrogation device evaluation (in person) with physician analysis, review, and report, includes connection, recording and disconnection per patient encounter; single, dual, or multiple lead implantable cardioverter-defibrillator system, including analysis of heart rhythm derived data elements	20
93290	Interrogation device evaluation (in person) with physician analysis, review, and report, includes connection, recording and disconnection per patient encounter; implantable cardiovascular monitor system, including analysis of 1 or more recorded physiologic cardiovascular data elements from all internal and external sensors	20
93291	Interrogation device evaluation (in person) with physician analysis, review and report , includes connection, recording and disconnection per patient encounter; Implantable loop recorder system, including heart rhythm derived data analysis	20
93292	Interrogation device evaluation (in person) with physician analysis, review, and report, includes connection, recording and disconnection per patient encounter; wearable defibrillator system	30
93293	Transtelephonic rhythm strip pacemaker evaluation(s) single, dual, or multiple lead pacemaker system, includes recording with and without magnet application with physician analysis, review and report(s), up to 90 days	15
93296	Interrogation device evaluation(s) (remote), up to 90 days; single, dual, or multiple lead pacemaker system or implantable cardioverter-defibrilator system, remote data acquisition(s), receipt of transmissions and technician review, technical suipport and distribution of results	20
93299	Interrogation device evaluation(s), (remote) up to 30 days; implantable cardiovascular monitor system or implantable loop recorder system, remote data acquisition(s), receipt of transmissions and technician review, technical support and distribution of results	20
93303	Transthoracic echocardiography for congenital cardiac anomalies; complete	45
93304	Transthoracic echocardiography for congenital cardiac anomalies; follow-up or limited study	20

93306	Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, complete, with spectral Doppler echocardiography, and with color flow Doppler echocardiography	60
93307	Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, complete, without spectral or color Doppler echocardiography	45
93308	Echocardiography, transthoracic, real-time with image documentation (2D) includes M-mode recording, when performed, follow-up or limited study	20
93312	Echocardiography, transesophageal, real-time with image documentation (2D) (with or without M-mode recording); including probe placement, image acquisition, interpretation and report	60
93315	Transesophageal echocardiography for congenital cardiac anomalies; including probe placement, image acquisition, interpretation and report	90
93320	Doppler echocardiography, pulsed wave and/or continuous wave with spectral display (List seperately in addition to codes for echocardiographic imaging); complete	10
93321	Doppler echocardiography, pulsed wave and/or continuous wave with spectral display (List seperately in addition to codes for echocardiographic imaging); follow-up or limited study (List separately in addition to codes for echocardiographic imaging)	8
93325	Doppler echocardiography color flow velocity mapping (List separately in addition to codes for echocardiography)	5
93350	Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report	60
93352	Use of echocardiographic contrast agent during stress echocardiography (List separately in addition to code for primary procedure)	1
93660	Evaluation of cardiovascular function with tilt table evaluation, with continuous ECG monitoring and intermittent blood pressure monitoring, with or without pharmacological intervention. A standard tilt table evaluation of 45 minutes or less qualifies for 45 RVUs. A complex tilt table evaluation of greater than 45 minutes qualifies for 90 RVUs. Evaluation time includes the time necessary to prepare the patient for the evaluation and any post evaluation services.	60/90
93701	Bioimpedance, thoracic, electrical	5
93724	Electronic analysis of antitachycardia pacemaker system (includes electrocardiographic recording, programming of device, induction and termination of tachycardia via implanted pacemaker, and interpretation of recordings)	15
93740	Temperature gradient studies	By Report
93745	Initial set-up and reprogramming by a physician of wearable cardioverter-defibrilator includes initial programming of	30

	system, establishing baseline electronic ECG, transmission of data to data repository, patient instruction in wearing system and patient reporting of problems or events	
93750	Interrogation of Ventricular Assist Device (VAD), in person, with physician or other wualified health care professional analysis of device parameters (eg, drivelines, alarms, power surges), review of device function (eg, flow and volume status, recovery), with programming, if performed, and report	15
93786	Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; recording only	10
93788	Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 ours or longer; scanning analysis with report	30
93799	Unlisted cardiovascular services or procedure (AICD Reprogramming)	By Report
G0166	External Counterpulsation, per treatment session	By Report

Contrast Codes

C8921	Transthoracic echocardiography with contrast, or without contrast followed by with contrast, for congenital cardiac anomolies, complete	45 (93303) + 1 for contrast = 46 RVUs
C8922	Transthoracic echocardiography with contrast or without contrast follwed by with contrast, for congenital cardiac anomolies; follow-up or limited study	20(93304) + 1 for contrast = 21 RVUs
C8923	Transthoracic echocardiography with contrst, or without contrast folloed by with contrast, real-time with image documentation (2D), includes M-mode recording, when performed, complete, without spectral or color Doppler echocardiography	45 (93307)+ 1 for contrast = 46 RVUs
C8924	Transthoracic echocardiography with contrast, or without contrast followed by with contrast, real-time with image documentation (2D), includes M-mode recording, when performed, follow-up or limited study	20 (93308)+ 1 for contrast = 21 RVUs

C8925	Transesophageal echocardiography (TEE) with contrast, or without contrast followed by with contrast, real time with image documentation (2D) (with or without M-mode recording); including probe placement, image acquisition, interpretation and report	60 (93312) + 1 for contrast= 61 RVUs
C8926	Transesophageal echocardiography (TEE) with contrast, or without contrast followed by with contrast, for congenital cardiac anomalies; including probe placement, image acquisition, interpretation, and report	90 (93315) + 1 for contrast = 91 RVUs
C8927	Transesophageal echocardiography (TEE) with contrast, or without contrast followed by with contrast, for monitoring purposes, including probe placement, real time 2-dimensional image acquisition and interpretation leading to ongoing (continuous) assessment of (dynamically changing) cardiac pumping function and to therapeutic measures on an immediate time basis	By Report
C8928	Transthoracic echocardiography with contrast, or without contrast followed by with contrast, real-time image documentation (2D), includes M-mode recoding, when performed, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report	60 (93350) + 1 for contrast = 61 RVUs
C8929	Transthoracic echocardiography with contrast, or without contrast followed by with contrast, real-time with image documentation (2D), includes M-mode recording, when performed, complete, with spectral doppler echocardiography, and with color flow dopper echocardiography	60 (93306)+ 1 for contrast = 61 RVUs

Codes Intentionally Omitted from List

93313	Placement of transesophageal probe only
93314	Echocardiography, transesophageal, real-time with image documentation (2D) (with or without M-mode recording); image acquisition, interpretation and report only.
93316	Placement of transesophageal probe only
93317	Transesophageal echocardiography for congenital cardiac anomalies; image acquisition, interpretation and report only.

93351	Echocardiography, transthoracic, real-time with image documentation (2D) , includes M-mode recording, when performed, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report; including performance of continuous electrocardiographic monitoring, with physician supervision
C8930	Transthoracic echocardiography, with contrast, or without contrast followed by with contrast, real-time with image documentation (2D), includes M-mode recording, when performed, during rest and cardiovascular stress using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report; including performance of continuous electrocardiographic monitoring, with physician supervision

Draft Recommendation:

HEALTH SERVICES COST REVIEW COMMISSION

Nurse Support Program II

FY 2014 COMPETITIVE INSTITUTIONAL GRANTS

May 1, 2013

This draft recommendation prepared by the Maryland Higher Education Commission staff is ready for HSCRC review. Please contact Oscar Ibarra with any questions or comments. Oscar.Ibarra@maryland.gov

INTRODUCTION

This paper presents the funding recommendations of the NSP II Grant Review Panel for the FY 2014 Nurse Support Program II (NSP II) Competitive Institutional Grants.

BACKGROUND

At the May 4, 2005 HSCRC public meeting, the Commission unanimously approved funding of 0.1% of regulated patient revenue annually over the next ten years for use in expanding the pool of bedside nurses in the State by increasing the number of nurse graduates. The primary goal of NSP II is to increase the number of bedside nurses in Maryland hospitals by expanding the capacity of Maryland nursing schools and increasing the number of nursing faculty. In 2006, the Governor introduced legislation to create a non-lapsing fund, the Nurse Support Assistance Fund, so that funds in which a portion of the Competitive Institutional Grants and Statewide Initiatives be used to attract and retain minorities to nursing and nurse faculty careers.

Following the approval of NSP II, the HSCRC assembled an advisory panel of academicians, business leaders, and nurse executives. The advisory panel held a series of meetings with the Maryland Association of Nurse Executives and the Deans and Directors of the State's Schools of Nursing. In response to the issues expressed by these two groups, the advisory panel crafted two distinct but complementary programs to address the multi-faceted issues surrounding the nursing faculty shortage: 1) Competitive Institutional Grants, and 2) Statewide Initiatives. The HSCRC contracted with the Maryland Higher Education Commission (MHEC) to administer the NSP II grants because of its expertise in postsecondary education including the administration of grants and scholarships.

On an ongoing basis, MHEC is responsible for NSP II grant pre–to-post award processes, including RFA development, and issuance, review panel management, awarding, disbursement of funds and ongoing compliance monitoring. In addition, the NSP II program manager works closely with the faculty project directors to facilitate collaboration and innovation through communication, joint meetings, on- site visits, and other advising services to NSP II grant awardees. In general, MHEC has implemented a coordinated, comprehensive approach balanced by achievement with accountability.

The Competitive Institutional Grants are designed to increase the capacity of Maryland Schools of Nursing through shared resources, innovative educational designs, and streamlining the process to produce additional nurse faculty. The Office of Outreach and Grants Management at the Maryland Higher Education Commission in consultation with the HSCRC staff, and the Deans, Directors and Department heads of nursing programs developed the FY 2014 Request for Applications. In developing the initiatives, national goals recommended by the

Institute of Medicine's (2010) report, *The Future of Nursing: Leading Change, Advancing Health* were taken into consideration,. These goals include increasing the percentage of BSN's and doubling the number of doctoral prepared nurses. This evidence- based report, as well as steering committees composed of hospital nursing leaders and nursing education leaders have reinforced the direction of both NSP I and NSP II, with new strategies in the development of a joint initiative, the Nurse Support Program website www.nursesupport.org .

The 2014 Competitive Grants supports:

1. Initiatives to implement the IOM's *Future of Nursing* report (2010) action oriented blueprint in the following recommendations.
2. Initiatives to implement innovative approaches to improved educational systems and increase clinical faculty.
3. Initiatives to facilitate inter-disciplinary education- promoting successful transitions by veterans and other displaced workers into nursing career paths.
4. Initiatives to maintain nursing student retention and success.
5. Initiatives to increase faculty development in workforce planning.

The Competitive Institutional Grant selection processes require a Grant Review Panel to review, deliberate, and recommend programs for final approval by the HSCRC. The applications are evaluated based on the criteria set forth in the Request for Applications (RFA), the comparative expected outcomes of each initiative, the geographic distribution of funded projects across the State, and the priority attached to attracting and retaining minorities in nursing and nursing faculty careers.

NSP II Competitive Institutional Grants from FY 2007 – FY 2013

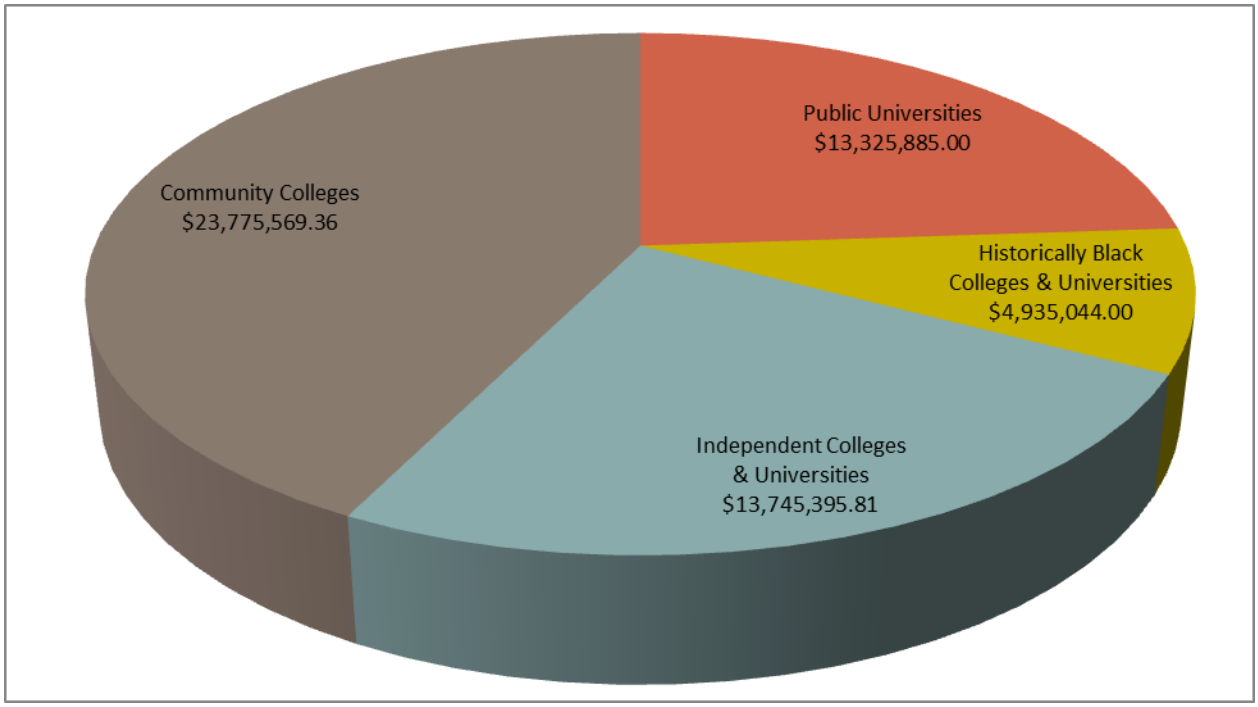
Between FY 2007 and FY 2013, 113 NSP II applications were received and 79 were approved for funding. Over that period of time, NSP II has provided $55,781,894 in funding to all 26 Maryland Schools of Nursing. **Exhibit 1** illustrates the distribution of funds by higher education institution type. The following types of programs have been supported by this grant program:

- Accelerated and innovative weekend, evening and 15 month degree options, especially appealing to working adult learners/ career changers;
- Developing models for dual enrollment for ADN and BSN programs;
- Increasing nursing faculty educational options through accelerated MSN and doctoral programs, including distance learning programs;
- New technology for simulation and instruction across the state offering clinical simulation networking in an open web-based format for sharing expertise and scenarios for increased educational capacity;
- Expanding online education instructional design technology with experienced faculty, thereby increasing access to undergraduate and

graduate nursing students and decreasing commuting issues for working adult learners and geographically disparate communities;

- Supporting new undergraduate and graduate nursing programs at Maryland's Historically Black Institutions (HBI), with the goal of increasing diversity of the nursing workforce; and
- Supporting regional approaches like The Eastern Shore Faculty Academy and Mentorship Initiative (ES-FAMI), a collaborative effort among the Departments of Nursing at public and private universities and community colleges, prepare experienced BS and MS-prepared registered nurses for new roles as part-time clinical nursing faculty

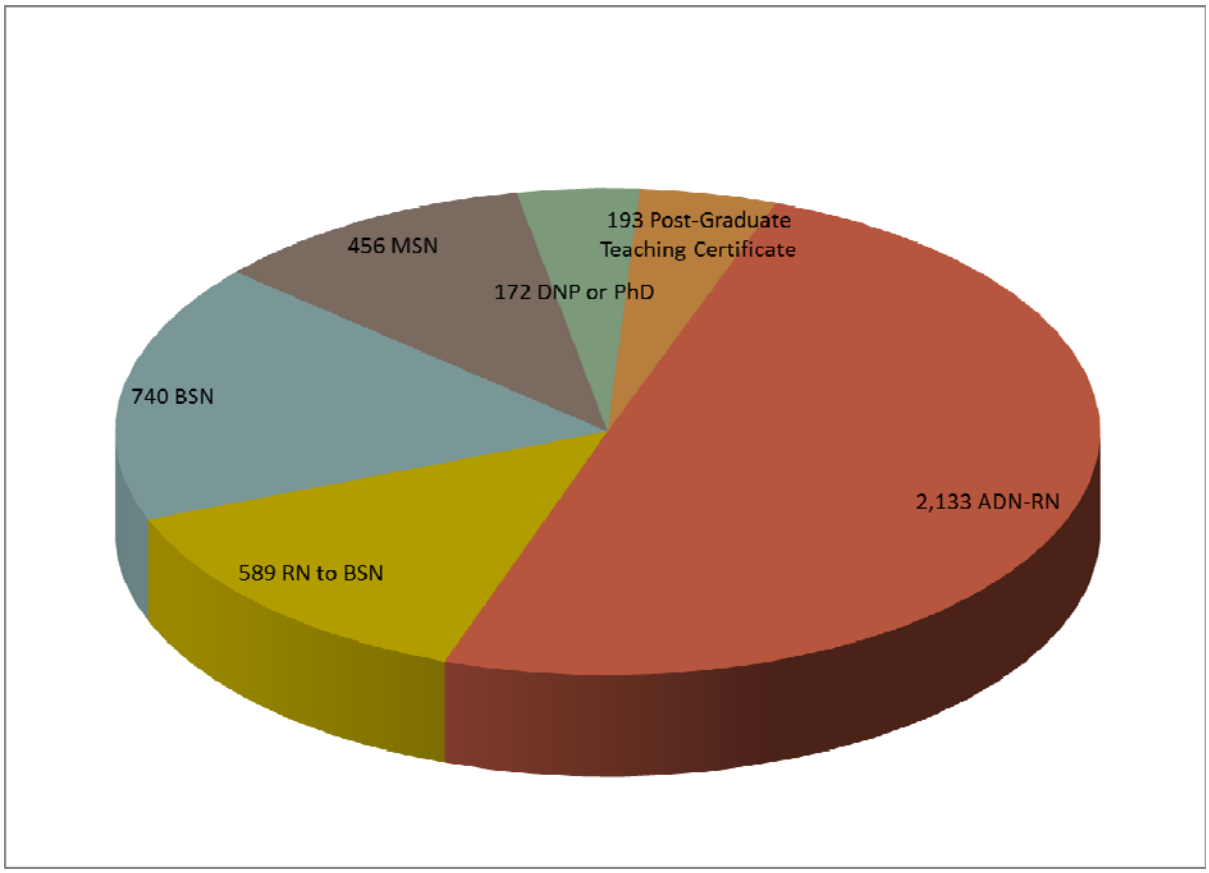
Exhibit 1: NSP II Competitive Grant Funding Summary by Higher Education Segment



Data from the Maryland Higher Education Commission (MHEC) and the Maryland Board of Nursing demonstrate success in increasing the number of nursing graduates in Maryland. In FY 2011, 3,429 nursing graduates completed programs designed for entry to practice with 2,519 passing NCLEX for licensure. This is an increase from the 2,615 new nursing graduates in FY 2006 with 2,039 passing NCLEX for licensure. Overall, the trend for five years has been a 19 percent increase in the number of new graduate nurses, and a 4.6 percentage point decrease in the hospital nurse vacancy rate. Nursing programs with current open grants reported to NSP II staff an average employment rate for new graduates of 85% by six months, with some areas, like northeastern Maryland reporting 100%.

Based on interim annual reports ending July 2012 and final reports ending March, 31, 2013, the Competitive Institutional Grant project outcomes demonstrate a dramatic contribution to the increase in the nursing workforce and advanced degrees for faculty preparation. Exhibit 2 illustrates degree completion information attributable to the grant from 2007 to 2012.

Exhibit 2: NSP II Competitive Grant Programs Degree Completions 2007 to 2012



NSP II has received international recognition for excellence in nursing workforce development. For example, MHEC is currently hosting a member of the Education Ministry in Taiwan, Mr. Charles Chen, who is very interested in implementing an NSP II type program in his country. MHEC's Director of Academic Affairs, Dr. Sue Blanshan, NSP II Program Manager Ms. Peg Daw, University of Maryland School of Nursing Dean Janet Allan and faculty member Dr. Barbara Smith, presentation/whitepaper featuring the NSP II program titled, *Nurse Faculty Shortage in the US: A Role of the State/ Province in Addressing the Shortage* was accepted at the 23rd International Nursing Research Congress symposia of the Sigma Theta Tau International Honor Society of Nursing. Drs. Blanshan and Smith presented the work at the conference in Brisbane, Australia in 2012.

The Nurse Support Program II has been referenced and highlighted in nursing and health care journals in multiple publications at the national level. For

example, a recent Robert Wood Johnson Foundation (RWJF) study, *RN Work Project* cited research from NSP II FY 06 and FY 09 project directors. The article on national research was developed collaboratively by professionals from University of Maryland and MedStar Franklin Square Medical Center. http://www.rwjf.org/en/about-rwjf/newsroom/newsroom-content/2012/12/why-nurses-go-back-to-school.html

NSP II project directors are also being recognized for nursing excellence and innovative work in leading change in Maryland.

- Dr. Rebecca Wiseman of University of Maryland School of Nursing and Ms. Barbara Nubile, Director of Nursing of Montgomery College, NSP II FY 2013 grant project, *Model for Dual Enrollment,* received matching funds from the RWJF State Implementation Grant (SIP) in March, 2013. The *Model for Dual Enrollment* is a possible strategy that could be implemented throughout Maryland via a variety of university-community college partnerships. http://www.nursing.umaryland.edu/news/4774

- NSP II FY 13 grant recipient for the a distance accessible *Doctor of Nursing Practice Program*, Dr. Lisa Seldomridge, was awarded the University System of Maryland's highest faculty honor, the *Regents' Faculty Award for Excellence* in April, 2013, "whose vision and leadership in nursing are transformative and ….her energy unmatched". http://www.salisbury.edu/newsevents/fullstoryview.asp?ID=5309

NSP II Competitive Institutional Grants for FY 2014

For FY 2014, 15 proposals were received. The seven member Grant Review Panel comprised of nursing administrators, hospital and emeritus university educators, and MHEC and HSCRC staff, reviewed all of the applications and ranked application according to a scoring rubric. All applications were recommended for funding with certain revisions as recommended by the Panel (Appendix I). The applications were diverse and representative of broad geographic locations and educational strategies. The most highly recommended applicant presented an innovative program for veterans with past or present status of a "Navy Corpsman", "Army 91WM6" or "USAF4NO" skill identifier. These individuals will be recruited to participate in an accelerated registered nurse program with expected completion in 13 months, through smooth transitions, online delivery and ongoing support systems. Five were focused on streamlining Associate Degree to Bachelor's completion. Several focused on advancing inter-professional education with simulation, improving minority outcomes, and leadership development. Other applicants are starting a new DNP program at an HBI, an RN- MSN program in western Maryland and a post-graduate psychiatric nurse practitioner option. Eleven Maryland schools and fourteen partner institutions will be involved in the fifteen proposed one to two year grant funded projects.

RECOMMENDATIONS:

1. Commission Staff recommends the draft of fifteen Competitive Institutional Grants recommended by the NSP II Grant Review Panel listed in Appendix I be considered by the Commission for FY 2014 in the funding amounts stated.

2. Staff recommends that the 30- day comment rule be observed so that this recommendation may be considered for final approval during the June Commission meeting.

NSP II FY 2014 Recommendations for Competitive Institutional Grants Program

Proposal	Name	School of Nursing	Total Request	Years	Year 1	Year 2
14-101	A Faculty Pipeline for RN to BSN and BSN to MSN	Bowie State University	$212,723	2	$105,586	$107,137
14-102	CCBC Associates to Bachelors (ATB)	CCBC	$298,957	2	$145,868	$153,089
14-103	Initiative to Promote Nursing Education as a Career Path	Coppin State University	$290,320	2	$151,875	$138,445
14-104	Planning the Pathway to an MSN in Western Maryland	Frostburg State University	$145,842	1	$145,842	
14-105	3 + 1 Model: A new route to the BSN	Hagerstown Community	$174,664	2	$82,079	$92,585
14-106	Interdisciplinary Simulation and Instructional Media to Enhance Student Success	Howard Community College	$268,290	2	$121,705	$146,585
14-107	Accelerated Post-NP Psychiatric Mental Health Nurse Practitioner Education	Johns Hopkins University	$299,709	2	$174,063	$125,646
14-108	Online Use of Interprofessional Simulation for Nursing and Faculty Development	Johns Hopkins University	$284,687	2	$158,407	$126,280
14-109	Establishing a Faculty Development Consortium for Nursing Leadership	Johns Hopkins University	$297,554	2	$150,848	$146,706
14-110	Military to ADN(M2ADN)	Montgomery College	$226,522	2	$115,359	$111,163
14-111	Increasing Success, Capacity & Outcomes in Minority Nursing Students	Sojourner-Douglass College	$237,351	2	$126,435	$110,916
14-112	Increasing Academic-Practice Partnerships in Maryland	Stevenson University	$276,942	2	$136,728	$140,214
14-113	Preparing Clinical Faculty for Maryland Nursing Schools	University of Maryland	$295,573	2	$130,208	$165,365
14-114	Increasing the Number of Baccalaureate Prepared Nurses in Maryland	University of Maryland	$298,915	2	$148,106	$150,809
14-115	Interprofessional Education: A faculty development initiative	University of Maryland	$299,928	2	$174,122	$125,806
Total	15 applicants		$3,907,977		$2,067,231	$1,840,746

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

John M. Colmers
Chairman

Herbert S. Wong, Ph.D.
Vice-Chairman

George H. Bone, M.D.

Stephen F. Jencks, M.D., M.P.H.

Jack C. Keane

Bernadette C. Loftus, M.D.

Thomas R. Mullen

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

Patrick Redmon, Ph.D.
Executive Director

Stephen Ports
Principal Deputy Director
Policy and Operations

Gerard J. Schmith
Deputy Director
Hospital Rate Setting

Mary Beth Pohl
Deputy Director
Research and Methodology

TO: Commissioners

FROM: Legal Department

DATE: April 24, 2013

RE: Hearing and Meeting Schedule

Public Session:

June 5, 2013 1:00 p.m., 4160 Patterson Avenue, HSCRC Conference Room

July 10, 2013 1:00 p.m., 4160 Patterson Avenue, HSCRC Conference Room

Please note, Commissioner's packets will be available in the Commission's office at 12:30 p.m.

The Agenda for the Executive and Public Sessions will be available for your review on the Thursday before the Commission meeting on the Commission's website.
http://hscrc.maryland.gov/commissionMeetingSchedule2013.cfm

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