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Research and Methodology

520th MEETING OF THE HEALTH SERVICES COST REVIEW COMMISSION

June 10, 2015

PUBLIC SESSION
8:00 a.m.

1. **Review of the Minutes from the Executive Session and Public Meeting on May 13, 2015**
2. **Executive Director's Report**
3. **New Model Monitoring**
4. **Docket Status – Cases Closed**
   2296A - Johns Hopkins Health System **2297A – University of Maryland Medical Center**
5. **Docket Status – No Open Cases**
6. **Final Recommendation for Shared Saving Program for Rate Year 2016**
7. **Final Update Factors Recommendations for FY 2016**
8. **Final Recommendation for Continued Support of the Maryland Patient Safety Center**
9. **Final Recommendation on Changes to the Relative Value Units Scale for Radiation Therapy Services**
10. **Final Recommendation on FY 2016 Nurse Support II Competitive Institutional Grants**
11. **Hearing and Meeting Schedule**

Minutes will be available after the Commission Meeting

and upon approval of the Commissioners

Executive Director's Report

The Executive Director's Report will be distributed during the Commission Meeting

New Model Monitoring Report

The Report will be distributed during the Commission Meeting

Cases Closed

The closed cases from last month are listed in the agenda

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

AS OF JUNE 1, 2015

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

NONE

PROCEEDINGS REQUIRING COMMISSION ACTION - NOT ON OPEN DOCKET

Final Recommendation for Shared Savings Program for Rate Year 2016

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

June 10, 2015

This document contains the final staff recommendations for implementing the Shared Savings Program for FY 2016.

A. Introduction

The Commission approved a shared savings policy on May 1, 2013, which reduced hospital revenues based on risk-adjusted readmission rates using specifications set forth in the Admission-Readmission Revenue Constraint Program (ARR). The program was developed to maintain Maryland's exemption from the CMS readmission program and required a reduction of 0.3 percent of inpatient revenues in the state during FY2014. This recommendation proposes the continuation of the shared savings policy, but suggests aligning the measurement definition to the definitions used in the Readmission Reduction Incentive Program and implementing interim limits for hospitals with changes above a threshold in shared savings amounts and those serving a higher proportion of adult Medicaid patients.

B. Background

Exemption Criteria from CMS Quality-Based Payment Programs

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 of reducing Medicare readmissions nationally. Medicare requires Inpatient Prospective Payment System (IPPS) hospitals outside of Maryland to engage in Medicare's Hospital Readmissions Reduction program. According to this IPPS rule published for FFY 2015, 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 nationally measured results for patient health outcomes and cost savings under the Medicare program. As mentioned in other quality-based payment recommendations, the new All-Payer model changed the criteria for maintaining exemptions from the CMS programs. As part of the CMMI contract, the aggregate maximum revenue at risk in Maryland quality/performance based payment programs must be equal to or greater than the aggregate maximum revenue at risk in the CMS Medicare quality programs.

Approved Methodology to Implement Shared Savings Program

The approved shared savings methodology the HSCRC used for the last two years calculated a case mix adjusted readmission rate based on ARR specifications (intra-hospital readmissions excluding 0-1 day stays with planned admission exclusions) for each hospital for the base period and determines a statewide required percent reduction in readmission rates 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. HSCRC staff then applies a shared savings benchmark to the case mix adjusted readmission rate to calculate the contribution from each hospital. The shared savings benchmark is the required percent reduction in readmissions necessary to achieve the predetermined revenue for shared shavings.

C. Assessment

1. Alignment of Readmission Measure

HSCRC staff is proposing to calculate risk-adjusted readmission rates of each hospital for calendar year 2014 using the measurement specifications developed for the Readmission Reduction Incentive program (RRIP) to be used as the basis of shared savings reductions, which includes readmissions to other hospitals. Staff believe that this alignment is important because hospitals need to be accountable for readmissions to other hospitals. Appendix I provides the CY 2013 case mix adjusted readmission rate under old and new methodology and the CY 2014 case mix adjusted readmission rates under the new methodology.

2. Proposed Required Revenue Reduction

HSCRC staff is proposing a statewide shared savings required revenue reduction of 0.6% of total hospital revenue. Because last year's statewide shared savings reduction of 0.4% is added back into rates, this represents an additional net reduction of 0.2%. Statewide required reductions in readmission rates are determined based on the proposed revenue reduction in total revenue as described in Table 1.

Table 1: Calculation of Statewide Reduction based on 0.6% of total revenue shared savings

FY 15 Total Approved Permanent Revenue	A	$14,984,632,041
Percent Inpatient	B	59.9%
Approved Inpatient Revenue	C = (A/B)	$8,977,162,630
Proposed Required Revenue Reduction %	F	0.60%
Proposed Required Revenue Reduction ($)	G=A*F	$89,907,792
Total Discharges Included	D	539,233
Average Approved Charge Per Case	E=C/D	$16,648
Readmission as a percent of Total Discharges	H	13.29%
Total Number of Readmissions	I = D*H	71,664
Required Reduction in Readmissions to achieve savings	J=G/E	(5,401)
Required New Readmission Rate	K=(I+J)/D	12.29%
Required Percent Reduction in Readmission Rate	L=K/H-1	**-7.54%**

Once the overall required reduction in readmission rates is determined, the hospital specific reduction as a percent of total revenue is calculated using the following formula:

*Inpatient revenue percent reduction= Hospital Risk-Adjusted Readmission Rate*Statewide required reduction in readmission rate*

The conversion to reduction as a percent of total revenue is calculated as follows:

*Total revenue percent reduction= Inpatient percent revenue reduction*proportion of total revenue from inpatient.*

The existing shared savings reductions policy has a number of advantages:

- Every hospital contributes to the shared savings; however, the shared savings are distributed in proportion to each hospital's 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 an equitable reduction for quality improvement related to readmissions reductions across all hospitals. Hospitals that reduce their intra-hospital readmission rates beyond the shared savings benchmark during the rate year will retain 100 percent of the difference between their actual reduction and the shared savings benchmark.
- When applied prospectively, the HSCRC sets and may adjust the targeted dollar amount for shared savings, thus guaranteeing a fixed amount of shared savings.

3. Hospital Protections

HSCRC staff is proposing two adjustments to the hospital-specific shared savings reductions:

- **Reduce the shared savings amounts for hospitals with changes above a threshold in shared savings penalty due to the change in the readmission measure.** Specifically, hospitals with an increase in the shared savings penalty of greater than 0.3% and had an improvement in readmissions from CY 2013 to CY 2014, will have the shared savings penalty capped at 0.3% of hospital total revenue for this year and will return to the full shared savings amount in subsequent years.

- **Reduce the shared savings penalty for hospitals with a higher proportion of adult Medicaid patients.** The HSCRC staff is concerned about ensuring hospitals that treat a higher proportion of disadvantaged patients have the needed resources for care delivery and care improvement, while not excusing poor quality of care or care coordination because of higher deprivation. The HSCRC has convened a subgroup to discuss risk-adjusting readmissions for socio-demographic factors, which had its kickoff meeting on May 1st and staff anticipate completing this work by fall. In the meantime, the staff is proposing that hospitals that are above the 75th percentile on the percentage of Medicaid discharges for those over age 18 should have shared savings reductions capped at the Statewide average of 0.6%. Discharges for adults were chosen in part due to the low readmission rates for children.

Appendix II provides the results of shared savings policy based on proposed 0.6% reduction in total patient revenues with and without these protections. In total the Statewide reduction is reduced to 0.59% with these protections.

D. Recommendations

The Staff is providing the following recommendations to the Commission for the Shared Savings for RY 2016:

- Align the shared savings readmission rate to the measure specified in RY 2017 Readmission Reduction Incentive Program.
- Set the value of the shared savings amount to 0.6 % of total permanent revenue in the state.
- Reduce hospital-specific shared savings reductions for hospitals with large changes from last year and those with higher proportion of adult Medicaid patients:
    - Hospitals with an increase in the shared savings penalty of greater than 0.3% and had an improvement in readmissions from CY 2013 to CY 2014, will have the shared savings penalty capped at 0.3% for this year and will return to the full shared savings amount in subsequent years.
    - Hospitals that are above the 75th percentile on the percentage of Medicaid discharges for those over age 18 should have shared savings reductions capped at the Statewide average of 0.6%.

Appendix I: Case Mix Adjusted Readmission Rates, CY 2013 and CY 2014

Hospital ID	Hospital Name	CY2013			CY2014 Using RRIP Definition						
		Case Mix Adjusted Rate using old ARR Definition	Case Mix Adjusted Rate using new RRIP Definition	Case Mix Adjusted Rate using new RRIP Definition Intra Only	Total Admissions in Denominator	Expected Readmissions *	Observed Readmissions	Observed Rate	Readmission Ratio	Case Mix Adjusted Rate	Case Mix Adjusted Rate Intra Only
		–	–		A	B	C	D=C/A	E=C/B	F=E*CY13 SWUnadj. Rate	
210001	MERITUS	8.22%	12.48%	11.15%	15,597	2080.1	1,907	12.23%	0.9168	12.71%	11.23%
210002	UNIVERSITY OF MARYLAND	6.72%	15.27%	8.68%	26,895	4213.8	4,559	16.95%	1.0819	14.99%	8.10%
210003	PRINCE GEORGE	5.50%	11.54%	6.67%	10,990	1532.9	1,181	10.75%	0.7704	10.68%	6.85%
210004	HOLY CROSS	6.90%	12.34%	8.86%	27,170	2939	2,753	10.13%	0.9367	12.98%	9.25%
210005	FREDERICK MEMORIAL	7.61%	11.42%	9.94%	14,737	2027.3	1,691	11.47%	0.8341	11.56%	10.10%
210006	HARFORD	6.24%	12.41%	8.38%	4,073	682.59	592	14.53%	0.8673	12.02%	8.75%
210008	MERCY	6.55%	15.57%	8.73%	13,594	1427.2	1,453	10.69%	1.0181	14.11%	7.71%
210009	JOHNS HOPKINS	8.30%	15.43%	11.13%	45,570	7033.6	7,816	17.15%	1.1112	15.40%	11.35%
210010	DORCHESTER	6.46%	12.56%	8.81%	2,340	406.42	367	15.68%	0.9030	12.51%	9.30%
210011	ST. AGNES	7.26%	14.90%	9.50%	15,436	2147.5	2,076	13.45%	0.9667	13.40%	8.34%
210012	SINAI	7.90%	15.14%	9.68%	21,301	3028.2	3,071	14.42%	1.0141	14.05%	8.54%
210013	BON SECOURS	7.13%	20.43%	8.98%	4,175	823.39	1,033	24.74%	1.2546	17.39%	6.10%
210015	FRANKLIN SQUARE	7.87%	14.03%	9.78%	20,820	2961.6	2,945	14.15%	0.9944	13.78%	9.41%
210016	WASHINGTON ADVENTIST	6.38%	12.11%	8.07%	10,946	1533.1	1,404	12.83%	0.9158	12.69%	8.51%
210017	GARRETT COUNTY	4.56%	7.72%	6.24%	1,821	215.27	113	6.21%	0.5249	7.28%	5.86%
210018	MONTGOMERY GENERAL	7.26%	13.44%	9.45%	7,837	1172.5	1,047	13.36%	0.8930	12.38%	8.02%
210019	PENINSULA REGIONAL	7.86%	11.90%	10.22%	16,879	2311.4	2,035	12.06%	0.8804	12.20%	10.53%
210022	SUBURBAN	6.81%	12.13%	8.87%	12,915	1866.3	1,598	12.37%	0.8562	11.87%	8.00%
210023	ANNE ARUNDEL	7.94%	12.97%	10.43%	24,086	2536.9	2,291	9.51%	0.9031	12.52%	9.53%
210024	UNION MEMORIAL	6.70%	15.25%	8.04%	11,770	1798.1	1,786	15.17%	0.9933	13.77%	6.26%
210027	WESTERN MARYLAND HEALTH SY	9.35%	13.14%	12.68%	10,884	1536.3	1,447	13.29%	0.9419	13.05%	12.60%
210028	ST. MARY	8.15%	13.40%	11.70%	6,503	875.99	710	10.92%	0.8105	11.23%	9.40%
210029	HOPKINS BAYVIEW MED CTR	8.26%	16.32%	10.32%	18,062	2642.4	2,914	16.13%	1.1028	15.28%	9.96%
210030	CHESTERTOWN	8.70%	14.75%	11.47%	1,766	288.43	271	15.35%	0.9396	13.02%	10.24%
210032	UNION HOSPITAL OF CECIL COUN	7.82%	10.88%	9.41%	4,959	747.22	579	11.68%	0.7749	10.74%	9.48%
210033	CARROLL COUNTY	7.79%	12.91%	10.32%	10,147	1414.3	1,289	12.70%	0.9114	12.63%	10.07%
210034	HARBOR	6.90%	13.94%	8.11%	6,787	898.36	876	12.91%	0.9751	13.51%	7.79%
210035	CHARLES REGIONAL	7.20%	12.93%	9.91%	7,041	984.56	940	13.35%	0.9547	13.23%	9.96%
210037	EASTON	6.25%	11.54%	8.76%	7,109	906.18	865	12.17%	0.9546	13.23%	10.03%
210038	UMMC MIDTOWN	5.63%	17.71%	6.41%	5,285	1052.1	1,266	23.95%	1.2033	16.68%	6.50%
210039	CALVERT	6.22%	10.57%	8.20%	5,273	733.93	482	9.14%	0.6567	9.10%	6.67%
210040	NORTHWEST	9.12%	16.03%	10.68%	10,216	1729.4	1,798	17.60%	1.0397	14.41%	8.60%
210043	BALTIMORE WASHINGTON MEDICA	8.25%	15.26%	11.14%	16,597	2528.5	2,674	16.11%	1.0575	14.66%	10.90%
210044	G.B.M.C.	6.09%	11.90%	7.90%	15,809	1764.6	1,426	9.02%	0.8081	11.20%	7.37%
210045	MCCREADY	4.97%	13.03%	6.36%	314	52.871	40	12.74%	0.7566	10.49%	6.38%
210048	HOWARD COUNTY	7.57%	12.90%	9.89%	15,465	1957.1	1,744	11.28%	0.8911	12.35%	9.59%
210049	UPPER CHESAPEAKE HEALTH	7.09%	12.68%	9.21%	10,784	1463.5	1,360	12.61%	0.9293	12.88%	9.10%
210051	DOCTORS COMMUNITY	7.07%	13.89%	9.22%	8,396	1423.9	1,221	14.54%	0.8575	11.88%	7.22%
210055	LAUREL REGIONAL	6.97%	14.91%	8.71%	4,263	609.21	603	14.14%	0.9898	13.72%	7.65%
210056	GOOD SAMARITAN	7.85%	15.15%	9.87%	10,078	1736.9	1,808	17.94%	1.0409	14.43%	9.45%
210057	SHADY GROVE	6.86%	11.87%	8.90%	18,632	2200.8	1,788	9.60%	0.8124	11.26%	8.10%
210058	REHAB & ORTHO	0.85%	12.70%	0.24%	2,449	287.39	262	10.70%	0.9117	12.63%	0.66%
210060	FT. WASHINGTON	6.48%	13.87%	6.96%	2,114	316.57	322	15.23%	1.0172	14.10%	6.77%
210061	ATLANTIC GENERAL	6.29%	13.00%	8.85%	3,093	492.89	435	14.06%	0.8825	12.23%	8.12%
210062	SOUTHERN MARYLAND	6.81%	12.74%	9.14%	12,269	1869.3	1,647	13.42%	0.8811	12.21%	8.73%
210063	UMST. JOSEPH	6.24%	12.67%	8.08%	15,986	1947.4	1,645	10.29%	0.8447	11.71%	7.37%
TOTAL		**7.36%**	**13.86%**	**9.55%**	**539,233**	**75,197**	**72,130**	**13.38%**	**0.9592**	**13.29%**	**9.09%**

Appendix II: Proposed Shared Savings Policy Reductions for Rate Year 2016

Hospital ID	Hospital Name	CY14 Risk Adjusted Rate	Inpatient Revenue Reduction	Proportion of Total Revenue from Inpatient	Percent Reduction in Total Revenue For RY 2016	Medicaid Adult Percentage	FY2015 Adjustment	Difference from Last Year	Percent Reduction in Total Revenue for FY16 w/Adjustments
A	B	C	D=C*Reduction	E	F=D*E	G	H	I = F - H	J
210001	MERITUS	12.71%	-0.96%	62.80%	-0.60%	19.22%	-0.47%	-0.13%	-0.60%
210002	UNIVERSITY OF MARYLAN	14.99%	-1.13%	68.95%	-0.78%	30.54%	-0.44%	-0.34%	-0.60%
210003	PRINCE GEORGE	10.68%	-0.80%	69.39%	-0.56%	41.92%	-0.35%	-0.21%	-0.56%
210004	HOLY CROSS	12.98%	-0.98%	69.47%	-0.68%	20.33%	-0.44%	-0.24%	-0.68%
210005	FREDERICK MEMORIAL	11.56%	-0.87%	57.44%	-0.50%	15.44%	-0.40%	-0.10%	-0.50%
210006	HARFORD	12.02%	-0.91%	46.61%	-0.42%	19.32%	-0.26%	-0.16%	-0.42%
210008	MERCY	14.11%	-1.06%	49.01%	-0.52%	25.25%	-0.29%	-0.23%	-0.52%
210009	JOHNS HOPKINS	15.40%	-1.16%	62.52%	-0.73%	23.07%	-0.48%	-0.25%	-0.73%
210010	DORCHESTER	12.51%	-0.94%	44.50%	-0.42%	27.44%	-0.29%	-0.13%	-0.42%
210011	ST. AGNES	13.40%	-1.01%	59.59%	-0.60%	19.94%	-0.39%	-0.21%	-0.60%
210012	SINAI	14.05%	-1.06%	62.60%	-0.66%	24.93%	-0.45%	-0.21%	-0.66%
210013	BON SECOURS	17.39%	-1.31%	61.90%	-0.81%	55.27%	-0.40%	-0.41%	-0.60%
210015	FRANKLIN SQUARE	13.78%	-1.04%	60.41%	-0.63%	26.71%	-0.43%	-0.20%	-0.60%
210016	WASHINGTON ADVENTIST	12.69%	-0.96%	65.05%	-0.62%	32.02%	-0.37%	-0.25%	-0.60%
210017	GARRETT COUNTY	7.28%	-0.55%	43.65%	-0.24%	20.03%	-0.17%	-0.07%	-0.24%
210018	MONTGOMERY GENERAL	12.38%	-0.93%	53.65%	-0.50%	13.24%	-0.35%	-0.15%	-0.50%
210019	PENINSULA REGIONAL	12.20%	-0.92%	57.61%	-0.53%	17.42%	-0.41%	-0.12%	-0.53%
210022	SUBURBAN	11.87%	-0.89%	64.95%	-0.58%	6.87%	-0.40%	-0.18%	-0.58%
210023	ANNE ARUNDEL	12.52%	-0.94%	57.36%	-0.54%	10.89%	-0.41%	-0.13%	-0.54%
210024	UNION MEMORIAL	13.77%	-1.04%	59.77%	-0.62%	22.62%	-0.36%	-0.26%	-0.62%
210027	WESTERN MARYLAND HEA	13.05%	-0.98%	59.25%	-0.58%	19.91%	-0.49%	-0.09%	-0.58%
210028	ST. MARY	11.23%	-0.85%	44.55%	-0.38%	17.46%	-0.33%	-0.05%	-0.38%
210029	HOPKINS BAYVIEW MED C	15.28%	-1.15%	60.26%	-0.69%	31.84%	-0.45%	-0.25%	-0.60%
210030	CHESTERTOWN	13.02%	-0.98%	49.52%	-0.49%	14.18%	-0.37%	-0.11%	-0.49%
210032	UNION HOSPITAL OF CEC	10.74%	-0.81%	44.83%	-0.36%	26.43%	-0.32%	-0.05%	-0.36%
210033	CARROLL COUNTY	12.63%	-0.95%	56.27%	-0.54%	15.10%	-0.40%	-0.13%	-0.54%
210034	HARBOR	13.51%	-1.02%	61.91%	-0.63%	33.54%	-0.39%	-0.24%	-0.60%
210035	CHARLES REGIONAL	13.23%	-1.00%	54.07%	-0.54%	17.02%	-0.34%	-0.20%	-0.54%
210037	EASTON	13.23%	-1.00%	51.99%	-0.52%	17.66%	-0.31%	-0.21%	-0.52%
210038	UMMC MIDTOWN	16.68%	-1.26%	62.77%	-0.79%	47.03%	-0.31%	-0.48%	-0.60%
210039	CALVERT	9.10%	-0.69%	48.73%	-0.33%	18.92%	-0.27%	-0.06%	-0.33%
210040	NORTHWEST	14.41%	-1.09%	58.28%	-0.63%	21.17%	-0.48%	-0.15%	-0.63%
210043	BALTIMORE WASHINGTON	14.66%	-1.10%	58.00%	-0.64%	16.90%	-0.43%	-0.21%	-0.64%
210044	G.B.M.C.	11.20%	-0.84%	48.29%	-0.41%	8.53%	-0.27%	-0.14%	-0.41%
210045	MCCREADY	10.49%	-0.79%	24.60%	-0.19%	15.29%	-0.11%	-0.09%	-0.19%
210048	HOWARD COUNTY	12.35%	-0.93%	61.11%	-0.57%	13.64%	-0.43%	-0.14%	-0.57%
210049	UPPER CHESAPEAKE HEAL	12.88%	-0.97%	50.00%	-0.49%	10.24%	-0.31%	-0.17%	-0.49%
210051	DOCTORS COMMUNITY	11.88%	-0.90%	62.83%	-0.56%	17.07%	-0.39%	-0.17%	-0.56%
210055	LAUREL REGIONAL	13.72%	-1.03%	64.81%	-0.67%	27.55%	-0.41%	-0.26%	-0.60%
210056	GOOD SAMARITAN	14.43%	-1.09%	61.85%	-0.67%	17.08%	-0.43%	-0.24%	-0.67%
210057	SHADY GROVE	11.26%	-0.85%	62.23%	-0.53%	16.77%	-0.39%	-0.14%	-0.53%
210058	REHAB & ORTHO	12.63%	-0.95%	59.98%	-0.57%	19.35%	-0.05%	-0.52%	-0.30%
210060	FT. WASHINGTON	14.10%	-1.06%	39.21%	-0.42%	14.15%	-0.25%	-0.17%	-0.42%
210061	ATLANTIC GENERAL	12.23%	-0.92%	38.88%	-0.36%	9.67%	-0.23%	-0.13%	-0.36%
210062	SOUTHERN MARYLAND	12.21%	-0.92%	63.74%	-0.59%	22.35%	-0.39%	-0.20%	-0.59%
210063	UM ST. JOSEPH	11.71%	-0.88%	60.98%	-0.54%	10.93%	-0.34%	-0.19%	-0.54%
Total	**Total**	**13.29%**	**-1.00%**	59.91%	**-0.60%**	**21.14%**	**-0.40%**	**-0.20%**	**-0.59%**

*75th Percentile for Medicaid +18 was 25.17%

Adj. due to >0.3% change

Eligible for Medicaid Adj.

Final Recommendations on Update Factors for FY 2016

Health Services Cost Review Commission
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May 13, 2015

This document contains the final Staff recommendations for the Update Factors for FY 2016.

Final Recommendations on Update Factors

INTRODUCTION

Overview

On July 1 of each year, the HSCRC updates hospitals' rates and approved revenues to account for inflation, policy adjustments, and other adjustments related to performance and settlements from the prior year.

On January 10, 2014, the Center for Medicare & Medicaid Innovation (CMMI) approved the implementation of a new All-Payer Model for Maryland. The All-Payer Model has a three part aim of promoting better care, better health, and lower cost for all Maryland patients. In contrast to the previous Medicare waiver that focused on controlling increases in Medicare inpatient payments per case, the new All-Payer Model focuses on controlling increases in total hospital revenue per capita. The Model establishes both an All-Payer limit of 3.58% cumulative annual per capita growth for Maryland residents for the first three years of the Model and a Medicare savings target of $330 million over the initial five-year period of the Model.

The update process needs to take into account all sources of hospital revenue that will contribute to the growth of total Maryland hospital revenues for Maryland residents in order to meet the requirements of the All-Payer Model and assure that the annual update approved by the HSCRC will not result in a revenue increase beyond the limit. In addition, HSCRC needs to consider the effect of the update on the Model's Medicare savings requirement and the total hospital revenue at risk for quality, care delivery, and value enhancement. While rates and global budgets are approved on a fiscal year basis, the All-Payer Model revenue limits and the Medicare savings are determined on a calendar year basis. Therefore, it is necessary to account for both calendar year and fiscal year revenues in establishing updates for the fiscal year.

There are three categories of hospital revenue under the All-Payer Model. The first two categories are under full rate setting authority of HSCRC. The third category of hospital revenue includes hospitals where HSCRC sets rates, but Medicare does not pay on the basis of those rates. The three categories are:

1. Hospitals/revenues under global budgets, including the Global Budget Revenue (GBR) agreements and Total Patient Revenue (TPR) agreements for 10 hospitals that were renewed July 1, 2013 for their second three-year term.
2. Hospital revenues that are not included under global budgets but are subject to rate regulation on an All-Payer basis by HSCRC, including hospital revenues excluded from a

global budget, such as revenues for non-residents at certain hospitals and the start-up years for Holy Cross Germantown Hospital.

3. Hospital revenues for which HSCRC sets the rates paid by non-governmental payers and purchasers, but where CMMI has not waived Medicare's rate setting authority to Maryland. This includes psychiatric hospitals and Mount Washington Pediatric Hospital.

This report includes final recommendations for FY 2016 updates.

STAKEHOLDER INPUT

The Payment Models work group provided staff with input on the draft FY 2016 update recommendations. Staff also received and reviewed written comments on the draft recommendations from CareFirst, the Maryland Hospital Association, the coalition of the TPR hospitals, and the Maryland Medicaid Program.

The Maryland Hospital Association expressed support for the recommendations with two proposed modifications:

- Revision of the proposed update for psychiatric hospitals and Mt. Washington Pediatric Hospital from 1.9 percent to 2.3 percent.
- Reconsideration of the amount set-aside for competitive grants after the commission has an opportunity to review the comprehensive care coordination plans that are due December 1, 2015.

CareFirst opposed the allocation of any additional funding to infrastructure investments given the recent favorable financial performance of Maryland hospitals and the opportunities to generate savings presented by global budgets. Both CareFirst and Maryland Medicaid recommended that the Commission carefully evaluate and monitor each hospital's use of any additional infrastructure funding. Specific suggestions included:

- More frequent reporting on the programs and activities funded with additional infrastructure dollars.
- Ensuring that at least a portion of the infrastructure dollars fund creation of common State-level infrastructure.
- Allocating funding based on achievement of specific milestones.
- Expecting and obtaining a return on investment in infrastructure in future updates. Monitoring the performance of hospitals in terms of reductions in avoidable readmissions and avoidable utilization.

All of the written comments received are enclosed in Appendix 3.

ANALYSIS

Calculation of Update Factors for Revenue Categories 1-3

In this final recommendation, we are focused on recommending the update factor that will be provided for inflation/trend for hospitals or revenues in each of the three categories. There are separate staff reports that provide recommendations on uncompensated care (approved by Commission in May) and shared savings relative to readmissions. The Commission was briefed at its April 15th meeting on a FY 2016 global contract adjustment to capture the ongoing impact of the Affordable Care Act's Medicaid expansion on hospital volumes.

The inflation/trend adjustment for Category 1 and Category 2 revenues starts by using the actual blended statistic of 2.40% growth, derived from combining 91.2% of Global Insight's FY 2016 market basket growth of 2.5% with 8.8% of the capital growth estimate of 1.4%. For those revenues that are not subject to global budgets, subtractions are made to reflect productivity and an additional reduction provided under the Affordable Care Act for Medicare. The 0.6% reduction for productivity is equivalent to the amount used in Medicare's proposed inpatient prospective payment system update for FY 2016, but Medicare makes other adjustments (e.g. -0.8% for coding) that have not been applied. As a result, the proposed rate adjustment would be as follows:

Table 1

	Global Revenues	Non-Global Revenues
Proposed base update	2.40%	2.40%
Productivity adjustment		-0.60%
ACA adjustment		-0.20%
Proposed update	2.40%	1.60%

For psychiatric hospitals and Mt. Washington Pediatric Hospital, we turn to the proposed psychiatric facility update for Medicare. Medicare applies a 0.6% reduction for productivity and 0.2% reduction for ACA savings mandates to a market basket update of 2.7% to derive a net amount of 1.9%. HSCRC staff initially proposed adopting the same factor and net adjustments for the Maryland psychiatric hospitals and Mt. Washington Pediatric Hospital. MHA argued that the Commission should also adjust for the 0.4% wage index budget-neutrality adjustment that

Medicare is making to its per diem rates. Staff do not recommend incorporating the budget-neutrality adjustment into Maryland's calculation. The adjustment does not reflect changes in underlying costs and there are other adjustments to the Medicare update (such as a decrease in payments for outlier patients) that depress the rate of payment growth. Recognizing that the specialty hospitals have an important role to play in reducing readmissions and other forms of avoidable utilization, staff recommend a 0.30% infrastructure adjustment for the specialty hospitals effective July 1, 2015. Specialty hospitals receiving the infrastructure funding will be required to:

- Submit a plan for enhancing care coordination and reducing avoidable utilization to the Commission by December 1, 2015; and

- Begin submitting admission and discharge data to CRISP no later than July 1, 2016 to facilitate monitoring of readmissions.

Summary of Other Policies Impacting FY 2016 Revenues

The update factor is just one component of the adjustments to hospital global budgets for FY 2016. In considering the system-wide update for the All-Payer Model, staff sought balance amongst the following conditions: 1) meeting requirements of the All-Payer Model agreement; 2) providing hospitals with the necessary resources to keep pace with changes in inflation and population; 3) ensuring hospitals have adequate resources to invest in the care coordination and population health strategies necessary for long-term success under the All-Payer model; 4) taking into account factors outside of the Model such as the Medicaid coverage expansion under the Affordable Care Act (ACA).

Table 2 summarizes the net impact on global revenues of staff proposals for inflation, volume, shared savings, infrastructure investments, uncompensated care, and the MHIP assessment. To facilitate an understanding of what the update means for hospitals and payers, adjustments are grouped into three categories:

- **Proposed revenue adjustments linked to ho spital cos t drivers an d performa nce.** This category is the best representation of the underlying new revenue available to hospitals to cover growth in costs and invest in improving care, improving health, and lowering cost. Inflation, volume, and infrastructure investments are included in this category along with shared savings and quality incentives. These adjustments provide hospitals with net revenue growth of 4.10% and per capita growth of 3.51%. An example of infrastructure includes care coordination resources for patients with complex needs and extensive chronic conditions.

- **Revenues adjustments that may n ot materialize.** A 0.5% placeholder is proposed for unforeseen adjustments. These funds may not all be allocated in FY 2016. If the funds are allocated, the gross revenue allocated to hospitals will rise to from 4.10% to 4.60%.

- **Revenue Reductions w ith neutral impact on hospital financial statements.** The decline in uncompensated care and the elimination of the MHIP assessment are included in this category. These items constrain the growth in hospital revenues and provide rate relief to payers without adversely impacting the hospitals. The hospital revenue reduction for the MHIP assessment is offset by hospitals' being relieved from paying the assessment. The decline in revenue for uncompensated care funding is based on an expected reduction in hospitals' uncompensated care levels, fueled by Medicaid payments for patients who were previously uninsured or underinsured. These two items reduce gross hospital revenue by a combined 1.41%.

The net recommended revenue growth combining the three categories is 3.19% with per capita growth of 2.61%. A more detailed summary of the adjustments is provided in Appendix 2. Descriptions and policy considerations are discussed for each step in the text below.

Table 2
Summary of Balanced Update Model

		Revenue Adjustments	Per Capita Adjustments
Revenue Adjustments Linked to Hospital Cost Drivers/Performance			
Inflation	A	2.40%	
Volume (population growth)	B	0.57%	
Medicaid Expansion - Ongoing Utilization Growth	C	0.38%	
Infrastructure (includes up to 0.25% for competitive grants)	D	0.59%	
Opening of Holy Cross Germantown Hospital	E	0.21%	
Shared Savings (net adjustment)	F	-0.20%	
Quality Incentive Payments	G	0.15%	
Planned Revenue Increase for Hospitals	**H= Sum of A thru G**	**4.10%**	**3.51%**
Reserve for Unforeseen Adjustments	I	0.50%	
Revenue Increase for Hospitals if All Reserves are Allocated	**J = H + I**	**4.60%**	**4.00%**
Adjustments with Neutral Impact on Hospital Financial Statements			
MHIP Assessment: Funds removed from rates; hospitals relieved from paying assessment	K	-0.57%	
Uncompensated Care: Amount in rates reduced; decline in rates offset by Medicaid payments for previously uninsured/underinsured patients	L	-0.84%	
Total Allowed Revenue Growth	**M = J + K + L**	**3.19%**	**2.61%**

Components of Revenue Change Linked to Hospital Cost Drivers/Performance

A number of factors linked to hospital costs and performance are accounted for including:

- **Adjustments for Volu me:** A 0.57% adjustment is recommended equal to the Maryland Department of Planning's estimate of population growth. Hospital specific adjustments will vary based on changes in the demographics of each hospital's service area. The net cost of market share and transfer policy adjustments will be absorbed within this volume allowance. Growth in revenue associated with unique (categorical exclusions) volumes such as transplants will also be funded from the 0.57% adjustment.

- **Impact of Medicaid Expansion:** As discussed in the staff's April report to the Commission, enrollees in the Affordable Care Act's Medicaid expansion are using more hospital services than they did prior to the expansion. Much of the increase reflects a temporary surge in demand for surgical procedures. The ongoing portion of the utilization uptick, after applying a 50% variable cost factor, is about $60 million

- **Infrastructure Adjustments:** Infrastructure adjustments of 0.325% in FY 2014 and an additional 0.325% in FY 2015 were included in global budgets to enable the successful transition to the new model. These adjustments recognized the need for investments in care management, population health improvement, and other requirements of global models. Successful care management and population health efforts will require hospitals to maintain and enhance their investments in addressing needs of complex patients, improving and coordinating care for individuals with chronic conditions, integrating and coordinating care with other hospital and non-hospital providers, and investing in IT, analytics, human resources, training, and alignment models to support these efforts. Recognizing the substantial scaling of infrastructure required, staff propose an additional 0.4% infrastructure investment in all GBR hospitals for FY 2016 No additional infrastructure funding is proposed for TPR hospitals. Generally, TPR hospitals were provided forward funding incentives considerably higher than the .65% infrastructure initially provided to GBR hospitals[1]. CareFirst opposes the provision of additional infrastructure funding arguing infrastructure needs should be funded out of savings generated by the hospitals. Well designed strategies should generate significant care improvements, health improvements, and returns on investment over time. Significant ongoing investments, however, are required in the near term to accelerate implementation of care coordination and provider alignment strategies and provide for sustainability for

[1] Garrett Hospital was not provided an incentive funding amount, and should be provided infrastructure allowances consistent with GBR hospitals.

Maryland hospitals under the All Payer Model as well as continuing preparation for an enhanced focus on total cost of care for all payers.

Hospitals should expect to spend a small portion of the new infrastructure funding to expand and enhance CRISP's ability to facilitate care coordination through the collection and sharing of data. A budget for CRISP's FY 2016 activities will be presented to the Commission at a future meeting.

Staff propose providing up to an additional 0.25% for competitive grants to hospitals to fund implementation of innovative care coordination, provider alignment, and population health strategies. All hospitals – including TPR and specialty hospitals – are eligible to compete for the funds. Grant proposals would be due December 1, 2015 with awards in January 2016 (Despite the mid-year award date, the amount of funding available for awards will amount to a full year of 0.25% to provide adequate seed money to launch each initiative). The amount of the grant awards would be a permanent 0.25% adjustment to hospital rates.

The performance requirements of the All-Payer Model contract necessitate the wise investment of infrastructure dollars in FY 2016 and future years. To provide the Commission with assurances that each hospital is engaged in the long-term success of the Model Contract, staff recommends that the Commission require each acute care hospital, including GBR, TPR, and other hospitals, to submit a plan by December 1, 2015 summarizing their short-term and long-term strategies and incremental investment plans for improving care coordination and chronic care, reducing potentially avoidable utilization, and aligning with non-hospital providers. These reports are important to understand the plans and strategies of hospitals under the new All Payer model, as well as to facilitate planning for continued development and focus on total cost of care. Continued receipt of the new FY 2016 infrastructure funding for GBR hospitals is contingent upon submission of a comprehensive plan. TPR hospitals have been provided the same inflation funding provided to GBR hospitals and were previously provided incentive funding. HSCRC has similar expectations of TPR hospitals and anticipates that TPR hospitals will focus on developing innovative approaches beyond the walls of hospitals to improve care delivery and population health.

Once the investment plans are received, aggregated and evaluated, the Commission will be in a better position to assess future needs, investment requirements, expected return on investment, etc. Both the Maryland Medicaid Program and CareFirst have recommended enhanced monitoring and evaluation of infrastructure investments. Staff agrees that the Commission must carefully monitor the use of the additional infrastructure funding and hold hospitals accountable for their investments. In addition to requiring the strategic

plan and continuing the annual infrastructure spending reporting requirement, staff intend to:

- Require hospitals to identify in their strategic plans specific process and quality measures that they will include in their annual infrastructure spending report. Staff also expect to collect data and monitor performance on outcome and process measures that pertain to all hospitals such as PAU spending and patients identified as in need of care coordination who have been assigned to a coordinator.

- Seek returns on investment for patients and payers in future updates by continuing and enhancing the shared savings program that provides for savings for expected reductions in potentially avoidable utilization;

- Engage consultants to assist HSCRC and DHMH staff in developing a plan template to guide hospitals' submissions, to assist in the review and evaluation of hospitals' strategic plans, to develop a learning collaborative together with the Maryland Hospital Association and other stakeholder organizations, and as necessary to provide technical assistance to hospitals with in developing plans;

- Evaluate the benefits of converting the annual infrastructure spending report to a biannual report and modifying the report to align with the strategic plans.

- **Certificate of Need (CON) Adjustments:** Holy Cross Germantown Hospital opened in the Fall of 2014. The FY 2016 increase annualizes last year's adjustment.

- **Other Adjustments:**

  - **Set-Aside for Unforeseen Adjustments:** Staff recommends a 0.5% set-aside to fund unforeseen adjustments during the year. A similar allowance was made for FY 2015.

  - **Reversal of Prior Year's Shared Savings Reduction:** The total FY 2015 shared savings adjustment is restored to the base for FY 2016, with a new adjustment (see below) to reflect the shared savings reduction for FY 2016.

  - **Shared Savings Reduction and Negative Scaling Adjustment:** The FY 2015 shared savings are continued and an additional 0.2% savings is targeted for FY 2016. A separate recommendation on this item will be made for the Commission's consideration.

- **Positive Incentives:** Positive incentives of 0.15% are expected to be paid in FY 2016 for performance on readmission and other quality metrics.

Components of revenue change with Neutral Impact on Hospital Bottom Lines

Several changes will decrease the revenues for FY 2016. These include:

a) **UCC Reductions:** The FY 2016 policy is the subject of a separate recommendation to the Commission. The Commission voted to approve the policy at its May 2015 meeting.

b) **MHIP/BRFA Adjustment:** The General Assembly's FY 2016 budget actions assume a zero assessment for the fiscal year. The FY 2015 assessment was 1% for the first quarter and 0.3% for the remainder of the year. This item also includes the removal of $15 million in one-time funding for care coordination and regional planning that was authorized in the Budget Reconciliation of Financing Act (BRFA) of 2014.

While Table 2 enumerates the central provisions leading to a balanced update for All-Payer Model overall, there are additional variables to consider such as one-time adjustments, as well as revenue and rate compliance adjustments and price leveling of revenue adjustments to account for annualization of rate and revenue changes made in the prior year.

Medicare's Proposed National Rate Update for FY 2016

Proposed updates to federal Medicare inpatient rates for 2016 have just been published in the Federal Register and are presented in the table below. The update will not be finalized for several months and could change. The base update provides growth of 1.1%, about half the 2.4% inflation/trend update proposed by the HSCRC. Additional adjustments including value based purchasing, hospital acquired conditions, readmissions, and the Disproportionate Share Hospitals reduce the expected growth in payments to 0.3%. These CMS projections do not include a provision for volume changes.

Table 3

Federal FY 2016	Proposed IP	Estimated OP based on IP
Base Update		
Market Basket	2.70%	
Productivity	-0.60%	
ACA	-0.20%	
Coding	-0.80%	N/A
	1.10%	1.90%
Other Changes		
Disproportionate Share	-1.00%	
Other Adjustments	0.20%	
	-0.80%	
Net Change to Payments	**0.30%**	

Applying the inpatient assumptions about market basket, productivity, and mandatory ACA savings to outpatient, staff estimate a 1.9% Medicare outpatient update effective January 2016. The estimated blended inpatient/outpatient Medicare increase for 2016 updates is about 0.7%.

Discussion of FY 2016 Balanced Update

The staff proposal properly increases the resources available to hospitals to account for rising inflation and upward pressure on volumes from population growth and the ACA expansion. Almost $100 million of the new funding is included for the development of the care coordination and population health infrastructure necessary for continued success. This new funding brings the total ongoing commitment for infrastructure over the period FY 2014 to FY 2016 to about $180 million for GBR hospitals - - an amount approaching the ongoing operating costs that the consultants supporting the care coordination workgroup pegged as an estimated level to fund care coordination across the State.

The proposed adjustments coupled with the ongoing incentives to reduce potentially avoidable utilization inherent to the model should allow the hospital industry to make significant additional investments while maintaining operating profits. Median operating profits year-to-date are about 3.5% with statewide profits at 2.8%. As discussed below, the proposed update is also within the financial parameters of the All-Payer agreement.

All-Payer Financial Test

The proposed balanced update keeps Maryland within the constraints of the model's All-Payer revenue test. Maryland's agreement with CMS caps the average annual growth rate for All-Payer per capita revenues for Maryland residents at 3.58%. Compliance with this test is measured by comparing the cumulative growth in revenues from the calendar 2013 base period to a ceiling calculated assuming annual per capita growth of 3.58%. This concept is illustrated in Table 4 below. As shown in the table, the maximum cumulative growth allowed through calendar 2016 is 11.13%.

Table 4
Calculation of Cumulative Allowable Growth
Per Capita All-Payer Revenues for Maryland Residents

	CY 14	CY 15	CY 16	Cumulative Growth
	A	B	C	D = (1+A)*(1+B)*(1+C)
Calculation of Revenue Cap	3.58%	3.58%	3.58%	11.13%

For the purpose of evaluating impact of the recommended update factor on compliance with the All-Payer test, staff have calculated the maximum cumulative growth that is allowable through the end of FY 2016 (the first 30 months of the waiver). As shown in Table 5, cumulative growth of 9.21% growth is permitted though FY 2016. Staff project actual cumulative growth through FY 2016 of 5.24%. This estimate reflects:

- Actual CY 2014 experience;
- The assumption that hospitals will use the full charge capacity available through their global budgets for the final six months of FY 2015 (January to June 2015); and
- The staff recommended update for FY 2016.

A decline in both uncompensated care and the MHIP assessment in FY 2015 and again in FY 2016 contribute to the magnitude of the gap between the maximum allowable cumulative growth and the projected growth. If not for these declines, per capita charges would grow by a cumulative 7.91% through FY 2016. Under either approach, the proposed update keeps Maryland within the limits of the All-Payer test.

Table 5
Proposed Update Leaves Maryland in Compliance with All-Payer Test Per Capita All-Payer Revenues for Maryland Residents

	A Actual Jan to June 2014	B Staff Est. FY 2015	C Proposed FY 2016	D=(1+A)*(1+B)*(1+C) Cumulative Thru FY 2016
Maximum Per Capita Revenue Growth Allowance	**1.79%***	**3.58%**	**3.58%**	**9.21%**
Per Capita Growth for Period	0.57%**	1.99%	2.61%	5.24%
Savings from Uncompensated Care & MHIP declines that do not adversely Impact Hospital Bottom Line		1.09%	1.41%	2.52%
Per Capita Growth with UCC/MHIP Savings Removed	**0.57%**	**3.07%**	**4.00%**	**7.80%**
Per Capita Difference Between Cap & Projection				**1.41%**

*3.58% annual growth divided by 2 to capture half year.
**1.13% growth divided by 2 to capture half year

Medicare Financial Test

The second key financial test under the model is to generate $330 million of Medicare fee-for-service savings over five years. The savings figure for the five-year period was calculated assuming Medicare fee-for-service costs per Maryland beneficiary would grow about 0.5% per year slower than national per beneficiary Medicare fee-for-service costs after the first year..

Preliminary calendar 2014 data currently under review by HSCRC contractors show a gap of nearly two percentage points between the Maryland (-1.5%) and national (+0.5%) per capita growth rates. If these numbers are correct, Maryland savings will exceed $100 million in year one of the model. While the first year savings are favorable, staff recommend maintaining the model contract goal of growing Maryland costs per beneficiary about 0.5% slower than the nation in FY 2016. Attainment of this goal will both maintain any ongoing savings from prior periods (retention of ongoing savings requires Maryland to limit its growth rate to the national rate in FY 2016) and grow those savings by roughly $30 million (from holding the Maryland growth rate below that of the nation again in FY 2016).

A commitment to continue the success of year one is critical to building long-term support for Maryland's model and to build a cushion against adverse performance in future years (for example from increased inflation or utilization expansion from the aging population).

The initial savings generated under the model contract could be adversely affected by:

- Modest projections for future national Medicare growth. As shown in Table 6 below, the CMS Office of the Actuary is forecasting just 0.3% growth in Medicare per beneficiary hospital spending in CY 2015 and 2.4% growth in CY 2016. Federal inpatient charge growth is constrained in the near term by modest inflation updates and steep decreases in disproportionate share payments. More robust outpatient growth is forecast due to increases in volumes. The out-year projections likely overstate this growth as recent announcements by Secretary Burwell indicate that Medicare will rapidly shift to alternative payment models for doctors and hospitals over the next few years in an effort to refocus financial incentives from growing volume to improving quality.

- Increasing Maryland's rates to cover more infrastructure may affect the savings levels in the short term, but should contribute to sustainability of the model and help limit future growth in utilization and costs.

Table 6
Per Capita Medicare Hospital Spending Projections
Office of the Actuary

	Per Capita Trend		
CY	Inpatient	Outpatient	Total Hospital
2013			
2014	-1.4%	11.0%	1.5%
2015	-2.0%	6.9%	0.3%
2016	1.4%	5.1%	2.4%
2017	2.5%	6.3%	3.5%
2018	4.5%	6.4%	5.0%

- A recent pattern of lower than expected growth in national Medicare costs. Projections of national per capita hospital trends by Medicare's Office of the Actuary have overstated the actual experience over the last couple of years as shown in Table 7 below. Even the February 2015 estimate of CY 2014 growth appears to overstate the actual trend as nearly real time data provided to Maryland though the waiver shows national CY 2014 spending growing at a rate of about 0.5% compared to the official estimate of 1.5%. The instability of the estimates creates risk for the State in establishing savings targets.

Table 7
Per Capita Medicare Hospital Spending Projections
February 2014 and February 2015 Estimates Compared
Office of Actuary

CY	Feb-14 Estimate	Feb-15 Estimate	% Point Difference
2014	1.70%	1.5%*	-0.2%
2015	1.70%	0.3%	-1.4%
2016	2.30%	2.4%	0.1%
2017	3.30%	3.5%	0.2%
2018	5.20%	5.0%	-0.2%

*Medicare fee-for-service data received by HSCRC shows national growth at 0.5% for CY 2014.

Allowable Growth

If the projections from the CMS Office of the Actuary for calendar 2015 and calendar 2016 are correct, national Medicare per capita hospital spending will increase by 1.35% in State FY 2016. The staff goal of limiting Maryland's Medicare per capita growth to 0.5 percentage points below the national rate results in a maximum allowable Medicare per capita growth of 0.85%.

For the purpose of evaluating the maximum All-Payer growth that will allow Maryland to meet the per capita Medicare fee-service growth target, the Medicare target must be translated to an All-Payer growth limit (Table 8). During deliberations on the FY 2015 update, CareFirst developed a "difference statistic" of two percentage points that was added to the Medicare target to calculate an All-Payer target. As shown in Appendix 1, Maryland's All-Payer per capita spending rose faster than Medicare fee-for-service per capita spending in each of the last six years and is on pace to do so again in FY 2015. The actual FY 2014 experience and the year-to-date experience for FY 2015 support the continued use of a two percentage point difference statistic.

Using the difference statistic, staff calculate that the maximum All-Payer per capita growth that will allow the State to realize the desired FY 2016 Medicare savings is 2.87%. The staff recommended update will produce the desired savings if national actuarial projections are accurate and the difference statistic correctly translates the Medicare growth to All-Payer growth (Table 9).

Table 8
Maximum All-Payer Increase that will Still Produce Desired FY 2016 Medicare Savings

Maximum Increase that Can Produce Medicare Savings		
Medicare		
Two year average of Medicare growth (CY 2015 + CY 2016)/2	A	1.35%
Savings Goal for FY 2016	B	-0.50%
Maximum growth rate that will achieve savings (A+B)	C	0.85%
Conversion to All-Payer		
Difference statistic between Medicare and All-Payer	D	2.00%
Conversion to All-Payer growth per resident (1+C)*(1+D)-1	E	2.87%
Converstion to total All-Payer revenue growth (1+E)*(1+0.57%)-1	F	3.45%

Note: National Medicare growth projection 0.3% for CY 2015 and 2.4% for CY 2016 from CMS Office of Actuary, February 2015 analysis.

Table 9

Comparison of Medicare Savings Goal to Model Results			
Comparison to Modeled Requirements	**All-Payer Maximum to Achieve Medicare Savings**	**Staff Recommended All-Payer Growth**	**Difference**
Revenue Growth	3.45%	3.19%	-0.26%
Per Capita Growth	2.87%	2.61%	-0.26%

Medicaid Deficit Assessment

The Medicaid deficit assessment for FY 2016 is unchanged from FY 2015, and the hospital funded portion and rate funded portion will remain at the same level and be apportioned to hospitals in a similar manner as FY 2015.

RECOMMENDATIONS

The final recommendations of the HSCRC Staff are as follows and are offered on the assumption that the other policy recommendations that affect the overall targets are approved (including the shared savings adjustment):

1) Provide update for the three categories of hospitals and revenues as follows:
   a) Revenues under global budgets--2.4% with an additional 0.4% provided for care coordination and population heath infrastructure investments;
   b) Revenues not under global budgets but subject to Medicare rate setting waiver--1.6%;
   c) Revenues for psychiatric hospitals and Mt. Washington Pediatric Hospital— 1.9% with an additional 0.30% provided for infrastructure investments to support reductions in readmissions and other potentially avoidable utilization.

2) Require all acute hospitals to submit multi-year plans for improving care coordination, chronic care, and provider alignment by December 1, 2015.

3) Require psychiatric hospitals and Mt. Washington Pediatric Hospital to submit a report outlining plans to reduce readmissions and other avoidable utilization by December 1, 2015 and to begin submitting admission and discharge data to CRISP by April 1, 2016.

4) Provide an additional 0.25% for competitive awards to hospitals to implement or expand innovative care coordination, provider alignment and population health strategies.

5) Calculate the Medicaid deficit assessment for FY 2016 at the same total amount as FY 2015 and apportion it between hospital funded and rate funded in the same total amounts as FY 2015.

Appendix 1

Difference Statistic

	All Payer	Medicare	Difference
FY 2009	5.4%	2.0%	3.40%
FY 2010	2.2%	-2.1%	4.30%
FY 2011	4.5%	2.9%	1.60%
FY 2012	5.0%	1.9%	3.10%
FY 2013	1.2%	-1.1%	2.30%
FY 2014	1.63%	-0.92%	2.55%
FY 2015 (thru Feb.)	0.87%	-0.79%	1.66%
Seven Year Average			2.70%
Average of FY 14 & FY 15			2.11%

For FY 2015, difference statistic of 2.0 percentage points was applied.

Appendix 2

Balanced Update Model

Components of Revenue Change Linked to Hospital Cost Drivers/Performance

		Weighted Allowance
Adjustment for inflation	A	2.40%
Adjustment for volume	B	0.57%
-Demographic Adjustment		
-Transfers ($1 M -$5 M impact)		
-Categoricals		
-Market share adjustments ($4 M est. impact)		
0.1%		
Utilization Impact of Medicaid Expansion ($60 M)	C	0.38%
Infrastructure allowance provided	D	0.59%
- 0.40% included in GBR rates on 7/1/15 (Net .34% adjustment since TPR & non-global revenues are excluded))		
- Upto another 0.25% allocated via a competitive process in January 2016		
CON adjustments-		
-Opening of Holy Cross Germantown Hospital	E	0.21%
Other adjustments (positive and negative)		
-Set aside for unknown adjustments	F	0.50%
-Reverse prior year's shared savings reduction	G	0.40%
-Positive incentives (Readmissions and Other Quality)	H	0.15%
-Shared savings/negative scaling adjustments	I	-0.60%
Net increase attributable to hospitals	J = Sum of A thru I	4.60%
Per Capita	K = (1+J)/(1+0.57%)	4.00%
Components of Revenue Change with Neutral Impact on Hosptial Finanical Statements		
-Uncompensated care reduction, net of differential	L	-0.84%
-MHIP (Assumes $0 MHIP in 2016)/2015 BRFA adjustment	M	-0.57%
Net decreases	N = L + M	-1.41%
Net revenue growth	O = J + N	3.19%
Per capita revenue growth	P = (1+O)/(1+0.57%)	2.61%

Appendix 3 – Comment Letters Attached

Maryland
Hospital Association

May 21, 2015

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

Dear Chairman Colmers:

On behalf of the Maryland Hospital Association's 65 member hospitals and health systems, I am writing in support of the Health Services Cost Review Commission (HSCRC) staff's fiscal year 2016 revenue update recommendation, with two proposed modifications:

- Reconsideration of the amount of funding to be made available for the competitive grants on January 1, 2016, based upon the comprehensive care coordination plans that all hospitals will be submitting on December 1, 2015
- Revision of the proposed update for psychiatric hospitals and Mt. Washington Pediatric Hospital from 1.9 percent to 2.3 percent

A Tectonic Shift

Eighteen months ago, Maryland's hospitals dove headfirst into our new all-payer model. Prior to January 1, 2014, per capita revenues were growing at an annualized rate of 6.8 percent, with very limited incentives to control utilization. Today, 95 percent of hospitals' revenue is governed by global budgets. Maryland's hospitals no longer rely on unit volume to secure financial stability and have committed to being accountable for controlling their total spending from that historical level of 6.8 percent to no more than 3.58 percent per capita. This new environment no longer regulates just hospital unit rates, but hospital global revenue growth. That seismic change in operating models required a corresponding change in thinking, policy, and regulation on the part of all stakeholders.

While still in its infancy, Maryland's bold experiment with this new all-payer model has already delivered highly encouraging results:

For patients:

- Statewide, there has been nearly a 16 percent reduction in potentially avoidable utilization from calendar years 2013 to 2014 (as a percentage of total hospital charges)
- Medicare readmissions rates, while falling short of our target, are declining faster than the nation as a whole
- Inpatient admissions and use rates are down more than 4 percent

For payers and the public:

- All-payer hospital spending growth per capita grew by an estimated 1.47 percent in calendar year 2014, well below the annual 3.58 percent ceiling

- Medicare hospital spending growth per beneficiary is down by 1.50 percent in 2014, well below national growth projections. This will save Medicare an estimated $100 million in 2014 alone, nearly one-third of the $330 million in savings required over the five-year experiment, and a remarkable achievement in light of the fact that no savings were required in the first year of our agreement with the Center for Medicare & Medicaid Innovation.

Shared Objectives

As we consider the global budget revenue update for fiscal year 2016, Maryland's hospitals remain mindful of the need to find more secure footing in the form of a "safety cushion," or reserve of funds, to ensure our collective ability to succeed over the course of this five-year experiment. Stakeholders are fully aware that the Centers for Medicare & Medicaid Services expects us to achieve the goals of the demonstration agreement, and Maryland's hospitals continue to embrace the opportunity to improve our performance as we meet those expectations.

HSCRC Advisory Council Guidance

As we evaluated the staff recommendation on the global budget revenue update for next year, we remained mindful of several important Advisory Council recommendations:

On meeting model requirements:
"*Global payment methods for Maryland hospitals should be the tool of preference to assure revenue controls."*

On meeting budget targets while making important investments:
"*The Advisory Council urges the HSCRC to strike a balance between near-term cost control, which is paramount, and making the required investments in physical and human infrastructure necessary for success. If we do not meet the near-term targets, there will be no long-term program. But if we fail to make the needed infrastructure investments, we will not have the toolkit of reforms necessary to achieve lasting success."*

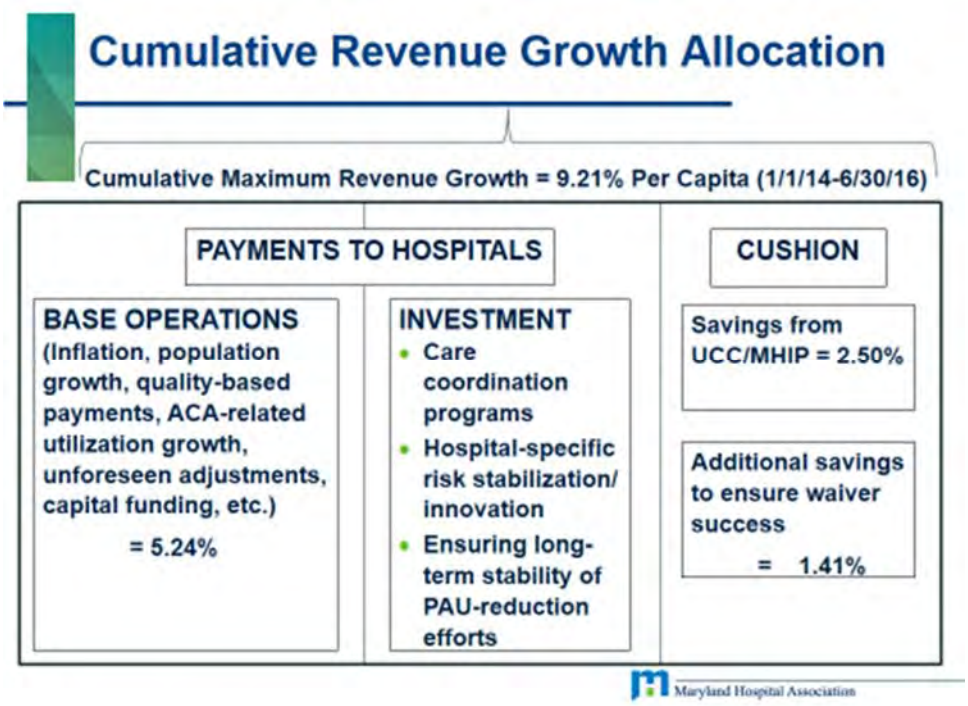
"*Given the challenging targets in this initiative, goals should be set in the aggregate as close to the targets as practicable…hospitals should be able to retain and reinvest a high percentage of their savings."*

On regulatory flexibility:
"*Within the context of per capita growth ceilings on hospital spending, HSCRC should allow considerable flexibility for the health care sector to implement its own strategies for achieving the desired results while recognizing the importance of following evidence-based best practices and the potential value of some standardization."*

"*The consensus of the hospital industry should have a significant weight in policy development…the Council recommends that the HSCRC give significant consideration and preference to policy recommendations that reflect a consensus among hospitals."*

These recommendations underline the delicate balance that commissioners must maintain between regulatory oversight and operational flexibility, and between investing for success and meeting the financial goals of the waiver – all while ensuring the financial stability of the field that has taken on

such significant risk under this new model. Because hospitals are now fully accountable for managing this risk under a global budget, the resources needed to mitigate the risk should reside with hospitals. This balancing act is reflected in the graphic below:



Hospitals readily and rapidly accepted this risk by shifting more than 95 percent of revenues to global budgets because they expected to be provided the tools and resources to get the job done.

For example:

- Based on preliminary infrastructure reports we have received from Maryland's hospitals, we estimate that the average global budget revenue hospital to date has invested about 1.1 percent of its total revenues in activities designed to make care better and more efficient, improve the health of their communities, and invest in novel, forward-thinking care programs. When compared with the infrastructure funding already provided, this suggests that an additional 0.50 percent in funding is needed to cover the programs that have already been implemented, slightly higher than the amount staff have recommended.
- As pictured above, based on the staff recommendation before you, the commission will have set aside more than 42 percent of the total potential cumulative hospital spending (3.91 percent of the total 9.21 percent) as a cushion to achieve the challenging financial targets of the all-payer model.

In the early years of system transformation, the work of reducing potentially avoidable utilization is both challenging and experimental. Based on the experience of Maryland's Total Patient Revenue (TPR) hospitals, it is unlikely that savings from reducing utilization will be sufficient to offset the

risk incurred under global budgets in these initial years. Only hospitals that have invested in and developed the foundation for sustained savings over time can count on using those savings for investment purposes. We believe that the additional resources recommended for fiscal year 2016 will help us build that foundation for long-term success.

We make two requests of commissioners as you consider this recommendation:

- As we work with staff to define the parameters of the comprehensive care coordination reports to be submitted by December 1, we ask that the commission reconsider whether the funding to be provided on January 1 will be sufficient to support those plans. As commissioners discussed at the May meeting, providing additional funding in competitive grants of up to 0.25 percent is to accelerate the implementation of the programs needed to ensure long-term waiver success. After commissioners have had the opportunity to review the plans that hospitals submit, they could determine the appropriate level of funding needed to ensure the timely implementation of the full range of acceptable plans, without limiting either the scope or number of programs implemented at that time.
- We also ask that the proposed update for psychiatric hospitals and Mt. Washington Pediatric Hospital be increased from the proposed 1.9 percent to 2.3 percent. Staff has used the proposed rule for the Medicare Inpatient Psychiatric Facility Prospective Payment System as the basis for its recommendation; based on MHA's reading of the proposed rule, we believe that the federal per diem is being increased by 2.3 percent.

Thank you for your consideration, and we look forward to your final action on the staff recommendation at the June meeting.

Sincerely,

Michael B. Robbins
Senior Vice President

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

Chet Burrell
President and Chief Executive Officer

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1501 S. Clinton Street, 17th Floor
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chet.burrell@carefirst.com

May 18, 2015

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

Donna Kinzer
Executive Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Re: HSCRC FY 2016 Hospital Update Factor DRAFT Recommendation

Dear Mr. Colmers and Ms. Kinzer:

CareFirst welcomes this opportunity to provide comments on the HSCRC staff's Draft Recommendation for the Update to Hospital Rates for the Fiscal Year ending 2016. We believe the staff has provided a balanced discussion of the key facts and issues in regard to this upcoming year's Update as it was developed through meetings with the HSCRC's Payment Work Group and in other venues.

We also believe it is important to temper an early sense of achievement under the waiver with the recognition that much remains to be done in the coming years. At this point, the rate of increase in hospital (and total) health costs has dropped precipitously throughout the U.S. Health costs are no longer growing as a share of the Gross Domestic Product (GDP). It is possible that we could meet our 3.58% limit on the growth in all payer hospital costs per resident in Maryland and find that our performance simply kept pace with the national average. If we merely meet the Medicare savings requirements, match the U.S. on All-Payer hospital cost growth, and fail to make improvements in quality as required in the Demonstration, we could find it difficult to persuade CMS to continue to support the Maryland waiver beyond the term of the current Demonstration contract.

In this context, we have serious concerns about the Update recommendation that would add 0.59% of infrastructure funding into the rates of the hospitals. The Global Budget Revenue (GBR) and Total Patient Revenue (TPR) arrangements that are in effect with all Maryland hospitals give them a great opportunity to generate savings by eliminating unnecessary volume while still getting paid up to their GBR target.

Accordingly, the hospitals are in a strong position to fund infrastructure investments using their own resources because such investments should generate positive returns. Hospital margins are at 2.8% on an overall operating basis (despite continued and significant losses on physician subsidies) and even higher (i.e., 5.0%) on regulated activities. Given these margins, shouldn't one of the highest uses of a portion of

the regulated margin be the development of an infrastructure that could enable each hospital to better achieve the objectives of the waiver? We believe the answer to this question is "yes". Hence, we do not believe there is a need to provide the hospitals with additional infrastructure funding at this time.

We also note that the Update Factor recommendation is significantly greater than CMS' current proposal for its Inpatient Prospective Payment System. We are concerned that the inclusion of the infrastructure adjustment will make it more difficult to meet the requirements of the waiver down the line?

We further believe that, to the extent that if the HSCRC approves infrastructure funding, it should only do so in the context of policy that would:

- Require the hospitals to report, on a periodic basis, in reasonable detail, the programs and activities they have implemented using any infrastructure money they have received;

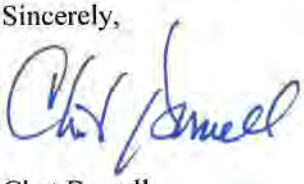
- Monitor the performance of the hospitals in terms of reductions in avoidable readmissions, reductions in potentially avoidable volume (PAU), reductions in unnecessary volume beyond the services reflected in the PAU calculations, and improvements in safety and quality of care; and

- Require the infrastructure investments to generate a payback (e.g., ROI) which should be achieved in the form of offsets to the Update factor in future years. The funding that is provided to the hospitals for infrastructure is paid for by public agencies, including Medicare and Medicaid, by employers and by patients. They are entitled to receive a return on their investment.

- Make any infrastructure allowance subject to change by the Staff if hospitals fail to fully document demonstrable results in improved performance related to such funding.

Thank you for giving us the opportunity to provide these comments.

Sincerely,



Chet Burrell
President and Chief Executive Officer

Transit Employees'

HEALTH AND WELFARE PLAN

metro

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May 13, 2015

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

Donna Kinzer
Executive Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Re: HSCRC 2016 Hospital Update Factor

Dear Mr. Colmers and Ms. Kinzer:

I want to thank the commissioners and the Commission staff for allowing me the privilege of participating in the Payment Models Work Group and to provide comments on the staff recommendation to the Update Factors. The staff and the other members of the work group have been very patient with me as I gradually get up to speed with this rate setting process.

I am the Executive Director of the Transit Employees' Health and Welfare Fund. We are the entity that pays the health and other benefits for the 12,000 active and retired members of ATU Local 689 employed by the Washington Metropolitan Area Transit Authority, about 70% of METRO's workforce

I represent a minority voice in this process: the voice of those plan sponsors that write the checks that provide the funds for carriers like CareFirst, United Health Care and Kaiser to pay hospitals. We are the ones whose bottom lines take the hit from increasing health care costs. We are the ones who must deduct increasingly larger amounts from our employees' pay checks in order to pay those health care bills.

Employers and workers across Maryland have for decades absorbed increases in health care costs that far exceed the rate of inflation and the rate of growth in the economy. It is partly because these increases are unsustainable that Congress passed the Affordable Care Act and that Maryland embarked on this pioneering effort to restructure the way that hospitals are paid

I have often repeated to others the words of an early story in the Washington Post. This is the most significant state initiative in the country next to Vermont. Now that Vermont's efforts to evolve into a single payer system have unfortunately floundered, the eyes of the nation are on Maryland

Those on the Payment Models Work Group have heard me say that I think the 3.58% allowable growth rate is far too generous and I applaud the efforts of the hospitals in Maryland to come in well under that target in its first year under this new model. We in the plan sponsor community face cost pressures from several directions. Just this past year the cost of our prescription drug program increased nearly 30% from first quarter 2014 to fourth quarter of 2014.

Those increases are largely attributable to new specialty medications for Hepatitis C that are expected to reduce long term inpatient and outpatient treatment costs for that disease. We are warned that many more very expensive treatments and cures are in the pipeline. Next up is PCSK9 a revolutionary drug to treat high cholesterol.

If we are spending more money on medications to reduce long term hospital costs, then we expect to see reductions in hospital costs, not just slower increases. In a recent article in the Journal of the American Medical Association (JAMA)[1], Don Berwick challenged the provider community to become leaders in making the changes necessary to achieve the goals of the Triple Aim. And he very specifically challenged those leaders to bring total spending on health care to under 15% of GDP.

From where I sit, Maryland is doing an outstanding job of bringing the provider community to the table to assume a leadership role in this process. But allowing hospital costs to track the growth in the Maryland economy will not reduce per capita spending and will never allow it to do Maryland's part to get health care spending below 15% of GDP.

Additionally a major concern of the employer community is the impending excise tax on so called "Cadillac Plans". This 40% marginal tax rate will eventually hit every single employer in Maryland, including the state of Maryland, perhaps the largest single group health plan in the state – unless total spending is reduced to below the rate of inflation – something that I don't think has happened to employer health care costs in my life time. The only way employers can avoid this tax is by shifting point of service costs on to their employees. Discussions at the Payment Model Work Group reveal that hospitals are having difficulty collecting these higher patient out of pocket expenses and it is affecting their bottom lines and the rate setting process.

In the first year of the waiver the hospitals have done an outstanding job of reducing revenue, improving quality while also enhancing their bottom lines. Who could ask for more? I see no reason, therefore, why the full .59% infrastructure allowance is necessary and ask the Commissioners to reconsider its inclusion in the final rate setting factors. Maryland hospitals have proven that they can meet their cost and quality targets without the additional money. Countless publications have described overuse and inappropriate volume in the system. Reducing those related costs should be sufficient to fund the necessary infrastructure improvements.

I would call attention to a slide presented at the last meeting of the Commissioners in April that showed that the median profit margin for Maryland hospitals increased by 1.18% - double what the commissioners are being asked to add to the rates for 2016 infrastructure improvement. So why is this additional money necessary?

However, if the infrastructure allowance is allowed to remain, then I ask that the Commissioners and staff to be vigilant to ensure that it is used to actually lower per capita health care costs in Maryland. I ask the Commissioners and the staff to expand its scope of unnecessary and inappropriate admissions by looking at population based metrics and benchmarking themselves against the best in class elsewhere in the nation.

That is the only way that Maryland will truly get the attention it deserves.

Thank you and I do hope that you will continue to involve the voice of the plan sponsor community in this process as you move forward.

Sincerely,

James L. McGee, CEBS
Executive Director

[i] Berwick DM, Feeley D, Loehrer S. Change From the Inside Out: Health Care Leaders Taking the Helm. *JAMA*. 2015;313(17):1707-1708. doi:10.1001/jama.2015.2830.

STATE OF MARYLAND
DHMH
Maryland Department of Health and Mental Hygiene
Larry Hogan, Governor - Boyd Rutherford, Lt. Governor - Van Mitchell, Secretary

May 12, 2015

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

Dear Chairman Colmers,

The Medicaid program has reviewed the Health Services Cost Review Commission's (HSCRC) Staff proposed rates for Fiscal Year 2016. We are writing to urge the HSCRC to build in more accountability for hospitals to receive monies for infrastructure development. Specifically, the recommendation of the HSCRC Staff for an update factor includes additional monies for infrastructure development—roughly 0.59 percent (or $84 million). This is in addition to the infrastructure adjustments included in global budgets for both FY 2014 and FY 2015—specifically, 0.325 percent for each year, for a cumulative amount of 0.65 percent (or $96 million).

The HSCRC Staff proposal will build 0.4 percent into rates starting July 1, 2015, but will require hospitals to submit a plan by December 1, 2015, to qualify for an additional 0.25 percent in rates.[1] HSCRC will review the hospital plans to determine whether an additional 0.25 percent is warranted. HSCRC Staff proposes requiring the hospitals to dedicate a portion of these infrastructure monies to the care coordination recommendations for common state-level support, which is estimated to cost around $51 million.

Medicaid strongly supports the creation of common state-level support; any release of infrastructure monies needs to include a requirement to fund these and the boarder care coordination recommendations.

The various proposals seeking Regional Partnership Planning Grants demonstrate that not all hospitals or regions are at the same level in their planning efforts—some areas need more technical assistance. Given this, any monies built into rates for infrastructure development that exceed the monies built into global budgets for FYs 2014 and 2015 and go beyond the

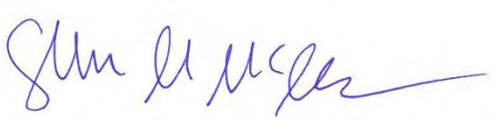
[1] The 0.65 percent is for the GBR hospitals. The net adjustment is 0.34 percent because TPR and non-global revenues are excluded.

recommendations of the care coordination workgroup need to be evaluated and monitored closely. HSCRC oversight needs to go beyond mere approval of the hospital plans, and recognize that the development of community resources must also be tied to broader population health accountability within the global budgets that will benefit all payers, including Medicaid.

Medicaid is specifically interested in assuring that Maryland may be able to benefit from reform efforts in other states that include robust accountability for community infrastructure development for hospitals. For example, under its recently-awarded DSRIP (Delivery Service Reform Incentive Payment) waiver, New York is requiring participating hospitals to create Performing Provider Systems statewide. Based on the results of a community needs assessment, these Performing Provider Systems select various pre-approved projects in the areas of system transformation, clinical improvement and population health. In turn, the State pays the Performing Provider Systems based on the achievement of certain milestones.

Medicaid looks forward to working with the HSCRC to develop additional mechanisms to ensure accountability and further the State's goal to transform the health care delivery system. If you have any questions, please contact Tricia Roddy, Director for the Office of Planning at 410-767-5809 or tricia.roddy@maryland.gov.

Sincerely,



Shannon M. McMahon
Deputy Secretary
Health Care Financing

UNION HOSPITAL

May 26, 2015

Ms. Donna Kinzer, Executive Director
State of Maryland Health Services Cost Review Commission
41600 Patterson Avenue
Baltimore, Maryland 21215

Dear Ms. Kinzer,

This letter presents the comments and suggestions of Western Maryland Hospital Center, Meritus Medical Center, Calvert Memorial Hospital, Union of Cecil County Hospital, Garrett County Memorial Hospital, and McCready Memorial Hospital ("TPR hospitals") relative to three subjects: the HSCRC staff's ("Staff") proposals for infrastructure funding in the FY-2016 annual update; the Staff's agreement to enhance the opportunity for certain appeals in connection with the Market Shift Adjustment ("MSA") calculations; and the inherent instability of the MSA statistics. Our suggestions related to the MSA are offered in the context of our strong support of global budget arrangements and the incentives of such arrangements to reduce marginal or unnecessary volumes of service and of our recognition of the need for market shift adjustments, provided that the MSAs comport with your stated objective of maintaining or strengthening the incentives of global budgets. We believe that this objective would be more effectively realized if our proposals for amending the MSA were adopted. Our comments and suggestions on all three topics are set forth in the following sections.

Infrastructure Funding

We support the need for infrastructure funding as a part of the All-Payer Model and understand that the Staff's proposal includes two components of the hospital's annual allowances dedicated to infrastructure funding:

- A .4% infrastructure adjustment applicable to the rates of all hospitals, including Garrett County Memorial Hospital ("Garrett"), that does not apply to the other TPR hospitals; and
- A .25% adjustment, effective on January 1, for hospitals selected in a competitive process involving proposals for infrastructure investments. This competitive process, as we understand it, does not exclude the TPR hospitals.

We understand that the TPR hospitals, other than Garrett and McCready Memorial Hospital ("McCready"), received infrastructure funding during the 2010/2011 TPR Agreement process and, therefore, Staff is recommending the .4% adjustment be withheld

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www.uhcc.com

from the 2016 increase for TPR hospitals. However, there is much left to do under the All-Payer Model that requires infrastructure investments by the TPR hospitals. Furthermore, such investments in support of coordinated care and other clinical management may substantially improve access and quality without improving a hospital's financial condition. Therefore, while we are grateful for the opportunity to compete for the second component of infrastructure payments in FY-2016, we would hope that additional infrastructure payments would be made available to the TPR hospitals in the succeeding years of the All-Payer Model.

The Opportunity to Appeal the Scope and Impact of the MSAs

As discussed more fully in the next section, we believe that a hospital's reductions in volume resulting from the application of evidence-based medicine or other clinical management initiatives may be incorrectly identified as a market shift and the savings associated with the initiative reduced or eliminated. Therefore, we strongly support the Staff's willingness to allow each hospital to identify product lines that are targeted by the particular hospital's clinical management initiatives and to exempt those product lines from the hospital's MSA calculation. These appeals will be especially useful in support of the clinical management initiatives funded by infrastructure payments and in support of similar initiatives to be carried out by the TPR hospitals. However, there are many clinical management initiatives such as home visits, SNF follow-ups, and IT investments that involve infrastructure expenditures with associated volume reductions that cannot be traced to individual product lines. Therefore, while the MSA appeals enhance the incentives of the global budget arrangements, we believe that these incentives need to be strengthened by further increasing the stability of the MSA statistics.

The Stability of the MSA Statistics

In the materials which we prepared for your consideration prior to our meeting on April 27th, we suggested that the ECMAD statistics calculated by zip code and product line were not sufficiently stable to ensure that changes in the distribution of the ECMADs over hospitals from one year to the next were actual market shifts rather than random fluctuations in the number and distribution of the ECMADs. In some product lines, including product lines that affect the MSA calculations of the TPR hospitals, the number and distribution of ECMADs in a geographic area is affected by a change in the supply of such services: a service, such as obstetrics, may close; one or more specialists at a hospital providing services in the product line may retire or change their hospital affiliation; or additional specialists may be recruited by a hospital, either as employed or attending physicians. However, the number and distribution by specialty of the physicians on the attending medical staffs of the TPR hospitals are generally stable from one year to the next. Therefore, the lion's share of the zip code and product line MSAs are not the result of changes in the supply of the product line services but rather random fluctuations in the number and distribution of such services.

The materials that we have submitted to you have suggested three relatively simple changes to the MSA formula intended to increase the actuarial stability of the underlying statistics. These changes were:

- To aggregate the zip codes in each Maryland county, calculating the MSAs by county and product line rather than by zip code and product line
- To limit the TPR MSAs to those Maryland zip codes included in the hospital's primary service area (PSA) as defined in the TPR Agreement
- To establish a budget neutral corridor derived from a hospital's Demographic Adjustment that would reduce positive MSAs and increase negative MSAs. The Demographic Adjustments are a form of volume allowance and are therefore appropriately offset against positive MSAs. The corresponding adjustment to the negative MSAs works to ensure budget neutrality of the MSA calculations.

In the aggregate, these proposed changes improved the impact of the MSA calculations on the TPR hospitals. However, as the primary purpose of the proposed changes was to increase the actuarial stability of the underlying statistics of the MSA calculation, the particular proposals were not selected so as to individually improve the MSA results for the TPR hospitals. Therefore, your decision to aggregate the zip codes of selected Maryland counties as a modification to the MSA increased the MSA offsets of the TPR hospitals that reduced their volumes of service and, in general, increased the MSA offsets of hospitals with volume reductions.

We do not believe that these increased offsets support the objectives of the All-Payer Model, in part, because they are not consistent with your stated principle of crafting the MSA methodology so as to maintain the incentives of the GBR target budgets.

Therefore, we would again suggest that the MSA calculations be subject to a budget neutral corridor following the precedent of the corridor limitations of the transfer policy, whereby a hospital's positive MSA would be reduced by the hospital's Demographic Adjustments; provided, that the reduced MSA would be greater than or equal to 0. With a corresponding increase for hospitals with a negative MSA, the corridors would substantially reduce the effects of random variation in the MSA calculations while enhancing the effect of the MSA on the incentives of the GBR target budgets.

We thank you for the opportunity to comment on the Staff's proposals for FY-2016 and for the substantial effort you have made in developing them. We would also like to thank you for your consideration of our past proposals and your helpful presentations at our meetings. We look forward to working with you in the future.

Sincerely Yours,

Kenneth S. Lewis, MD, JD

Final Recommendations on Continued Financial Support for the Maryland Patient Safety Center for FY 2016

June 10, 2015

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

This is a final Recommendation to be considered at the June 10, 2015 HSCRC public meeting.

Final Recommendations on Continued Financial Support of the Maryland Patient Safety Center for FY 2016

Introduction

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 11 years, the rates of eight Maryland hospitals were increased by the following amounts in total, 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
- FY 2014 - $1,200,000
- FY 2015 - $1,080,000

In April 2015, the HSCRC received the attached request for continued financial support of the MPSC through hospital rates in FY 2016 (Appendix I). The MPSC is requesting a total of $972,000 in funding support from HSCRC, a decrease of 10% from the previous year.

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 initially 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 authorized 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 then reorganized as an entity independent from MHA and the Delmarva Foundation and subsequently re-designated by MHCC as the state's patient safety center for two additional five year periods; the Center's current designation extends through December 2019.

Assessment

Strategic Partnerships

The MPSC 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 2016 and beyond include private and public agencies and organizations working across the continuum of care to improve patient safety (Appendix I).

Maryland Patient Safety Center Activities, Accomplishments, and Outcomes

The MPSC's core activities for FY 2015, including their current status and summaries of provider participation, are listed in in Figure 1 below.

Figure 1. MPSC FY 2015 Core Activities

FY 2015 Activity	Status/Participation
Maryland Hospital Hand Hygiene Collaborative	Collaborative Ended in October 2014
Safe from Falls Long Term Care	21 LTCs participating; will continue into FY16
Improving Sepsis Survival	Cohort I 10 hospitals; Cohort II 11 hospitals; will Continue into FY16
Perinatal/Neonatal Learning Network	33 Maryland hospitals; 1 DC hospital; 1 Northern VA hospital-learning network will convert to two collaboratives

Final Recommendations on Continued Financial Support of the Maryland Patient Safety Center for FY 2016

FY 2015 Activity	Status/Participation
Patient Safety Certification	Pilots in 3 organization near completion; once data and evaluation complete will begin to market to organizations in FY 16
Caring for the Caregiver	Pilots in 2 organizations near completion
Adverse Event Reporting	Contracting with Quantros (vendor) to map data from the various hospital systems to the MPSC. Recruiting hospitals to test the mapping.

The highlights of the Center's key accomplishments for FY 2015, more fully outlined in Appendix I, include:

- Initiated pilots of the Patient Safety Certification program in two hospitals and one long-term care facility
- Initiated pilots of the Caring for the Caregiver program in two hospitals
- Focused education on OB hemorrhage preparation contributing to a decreased rate of OB hemorrhage deaths
- Established a cooperative relationship with new Quality Improvement Organization/Network, VHQC
- Maryland Hospital Hand Hygiene Collaborative completed with twelve consecutive months at a goal of 90% or greater aggregate compliance
- Kicked off the innovative Improving Sepsis Survival Collaborative focused on decreasing mortality rates for severe sepsis and septic shock
- Decreased falls with injury in participating long-term care facilities by 27.3% (July 2014 - February 2015)

As illustrated in Figure 2 below, for FY 2016, the Center anticipates it will complete work in some areas (e.g., LTC Safe From Falls Collaborative), continue several of the projects from FY 2015 (e.g., Caring for the Caregiver Project, Patient Safety Certification, Improving Sepsis Survival Collaborative), and begin work on new projects important for patient safety in the State (e.g., Reduction of First Time C Sections and Standardizing Care and Treatment of Neonatal Abstinence Syndrome).

Figure 2. MPSC FY 2016 Projects

FY 2016 Activity	Status/Expected Participation Target
Safe from Falls Long Term Care	21 LTCs participating; collaborative to end December 2015
Improving Sepsis Survival	Cohort I 10 hospitals- ends June 2016; Cohort II 11 hospitals- ends May 2017
Hand Hygiene LTC	Recruiting has begun and hope to recruit at least 50 LTCs to participate

Reducing First time C-Sections	Recruitment to begin in July 2015 and hoping to have all 33 Maryland birthing hospitals
Standardizing Care and Treatment of Neonatal Abstinence Syndrome	Recruitment to begin in July 2015. Of the 33 birthing hospitals 15 are Level III NICUs- hope to at minimum have all 15 and at least a few Level II NICUs.
Clean Environment	Collaborative recruitment to start July 2015. Goal is for 40 hospitals, 20 LTCs
Patient Safety Certification	Once results and evaluation complete, plan to use data to market to organizations- expect to have data in early fall 2015
Caring for the Caregiver	Pilots in 2 organizations near completion; plan to begin marketing for implementation at the start of July 2015
Adverse Event Reporting	Contracting with Quantros (vendor) to map data from the various hospital systems to the MPSC. Continue to recruit hospital participants.

FY 2016 Projected Budget

MPSC continued its efforts to work with its partners to secure program-specific funding for FY 2016, and estimates the amounts they will secure for FY 2016 in Figure 3 below.

Figure 3. Proposed Revenue and Expenses

Maryland Patient Safety Center
FY 16 Budget

	FY 2015 Budget	FY 2016 Budget
REVENUE		
Cash Contributions from MHA/Delmarva	200,000	100,000
Cash Contributions from Hospitals	151,350	75,000
Cash Contributions for Long-term Care	25,000	25,000
HSCRC Funding	1,080,000	972,000
Membership Dues	247,500	275,000
Education Session Revenue	35,000	22,000
Conference Registrations-Annual MedSafe Conference	7,000	3,000
Conference Registrations-Annual Patient Safety Conference	157,500	130,000
Sponsorships	128,000	130,000
Program Sales	50,000	60,000
DHMH Grant	250,000	200,000
Other Grants/Contributions	135,000	100,000
Total Revenue	2,466,350	2,092,000

EXPENSES	FY 2015 MPSC	FY 2015 Consultants	FY 2015 Total	FY 2016 MPSC	FY 2016 Consultants	FY 2016 Total
Administration	538,000		538,000	551,250		551,250
Outpatient Dialysis (previously committed)	-		-	-		-
Programs			-			-
Education Sessions		98,000	98,000		78,000	78,000
Annual Patient Safety Conference		400,000	400,000		360,000	360,000
MEDSAFE Conference		55,000	55,000		55,000	55,000
Caring for HC	67,500	130,000	197,500	57,000	60,000	117,000
Patient/Family Centered Care	-	-	-	-	-	-
Safety Initiatives-Perinatal/Neonatal	250,000	-	250,000	221,300	-	221,300
Safety Initiatives-Hand Hygiene	87,500	7,500	95,000	52,050	15,000	67,050
Safety Initiatives-Safe from Falls	52,250	250	52,500	24,600	500	25,100
Safety Initiatives-Adverse Event Reporting	21,000	84,000	105,000	15,600	85,000	100,600
Patient Safety Certification	115,500	285,000	400,500	117,400	52,000	169,400
Sepsis	169,000	17,500	186,500	71,500	87,900	159,400
Clean Environment	-	-	-	81,600	105,000	186,600
Total Expenses	1,300,750	1,077,250	2,378,000	1,192,300	898,400	2,090,700
Net Income (Loss)			88,350			1,300

MPSC Return on Investment

As was noted in the last several Commission recommendations, the All-Payer System has provided funding support for the Maryland Patient Safety Center 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, these results are difficult to quantify and the Center has been able to provide 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.

MPSC implemented its Hand Hygiene and Improving Sepsis Survival programs to target safety improvement of hospital infections. To monitor progress on potentially related indicators, the MPSC analyzes the data self-reported by hospitals (Appendix I), as well as the data provided by HSCRC on infection-related Potentially Preventable Complications (PPC) used in the Maryland Hospital Acquired Conditions (MHAC) program, and inpatient mortality related to sepsis. HSCRC notes that there has been an almost 1% reduction in inpatient mortality statewide for patients with sepsis from CY 2012 to CY 2014 (from 29.7% to 28.8%). In addition, there have been significant reductions in ten out of twelve infection-related PPCs as illustrated in Figure 4 from CY 2013 to CY 2014.

Figure 4. Reduction in Infection PPCs, CY 2013 to CY 2014

PPC NUMBER	PPC DESCRIPTION	RISK ADJUSTED RATE CY2013	RISK ADJUSTED RATE CY2014	IMPROVEMENT PERFORMANCE
5	Pneumonia & Other Lung Infections	1.2570	0.9149	-27.22%
6	Aspiration Pneumonia	1.2573	1.0515	-16.37%
33	Cellulitis	1.2583	0.9845	-21.76%
34	Moderate Infectious	1.3159	1.1925	-9.38%
35	Septicemia & Severe Infections	1.2555	0.8969	-28.56%
37	Post-Operative Infection & Deep Wound Disruption Without Procedure	1.2628	1.0859	-14.01%
38	Post-Operative Wound Infection & Deep Wound Disruption with Procedure	1.1988	0.8004	-33.24%
52	Except Vascular Infection	1.2619	0.9359	-25.83%
53	Catheters & Infusions	1.2770	1.0863	-14.94%
54	Infections due to Central Venous Catheters	1.2948	1.3111	1.25%
64	Other In-Hospital Adverse Events	1.2505	0.8899	-28.84%
66	Catheter-Related Urinary Tract Infection	1.2615	2.0611	63.39%

Based on the reports MPSC has provided and on analysis of HSCRC data, although direct cause and effect relationships can't be established, staff continues to believe that the programs of the MPSC are well conceived. The new sepsis prevention program aligns with the Commission's goals as it aspires to reduce infection complications and mortality. MPSC has continued to work diligently at establishing relationships with providers across the continuum of care in the past year, and to maintain sources of revenue, particularly in conference registration fees and in membership dues, demonstrating perceived value of the Center's provider customer base.

Recommendations

In light of the information presented above, staff provides the following recommendations on the MPSC funding support policy:

1. HSCRC provide funding support for the MPSC in FY 2016 through an increase in hospital rates in the amount of $972,000, a $108,000 (10%) reduction from FY 2015;
2. 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, and maintain reasonable cash reserves;
3. Going forward, HSCRC continue to decrease the dollar amount of support by a minimum of 10% per year, or a greater amount contingent upon:
    a. how well the MPSC initiatives fit into and line up with a broader statewide plan and activities for patient safety; and
    b. whether new MPSC revenues should offset HSCRC funding support.

Appendix I: MPSC Report to HSCRC on FY 2015 Results and FY 2016 Program Plan and Budget Request

Maryland Patient Safety Center
FY 2016 Program Plan & Budget

Presented to the Health Services Cost Review Commission

March 2015

Creation of the Maryland Patient Safety Center

- In 2001, the Maryland General Assembly passed the "Patients' Safety Act of 2001" charging the Maryland Health Care Commission (MHCC) with studying the feasibility of developing a system for reducing the incidence of preventable adverse medical events in Maryland
- In 2003, legislation was passed establishing the Maryland Patient Safety Center
- In 2004, the MHCC solicited proposals from organizations to create the Maryland Patient Safety Center. They approved a joint proposal from the Maryland Hospital Association and the Delmarva Foundation
- In 2004, designated by the MHCC as the state's Patient Safety Organization through 2009. Re-designated in 2014 through 2019
- In 2007, the Maryland Patient Safety Center was incorporated as a 501(c)(3) organization
- In 2008, listed as a federal Patient Safety organization and relisted through 2017

Appendix I: MPSC Report to HSCRC on FY 2015 Results and FY 2016 Program Plan and Budget Request

Maryland Patient Safety Center Board of Directors

- Susan Glover, Chair, SVP, Chief Quality Officer Adventist HealthCare
- Gerald Abrams, Director
  Abrams, Foster Nolo & Williams, PA
- John Astle, Senator, District 30 (D)
  Maryland State Senate
- Carmela Coyle, President & CEO
  Maryland Hospital Association
- Joseph DeMattos, Jr., MA, President
  Health Facilities Association of Maryland
- Barbara Epke, Vice President
  LifeBridge Health
- E. Robert Ferrell, PharmD, FASHP, FMSQS
  Medication Safety Officer
  Johns Hopkins Hospital
- Eugene Friedman, Former Corporate Counsel
  1st Mariner Bank
- Chris Goeschel, ScD, MPA, MPS, RN
  Corporate Assistant Vice President, Quality
  MedStar Health
- Warren Green
  Former President and CEO
  LifeBridge Health
- William Holman, President & CEO
  Charles County Nursing & Rehabilitation Center
- David Homocki, President
  CMSP
- Andrea M. Hyatt, President
  Maryland Ambulatory Surgery Association
- Robert Imhoff, President & CEO
  Maryland Patient Safety Center
- Joanna Kaufman, Program / Information Specialist
  Institute for Patient Family-Centered Care
- Lawrence Linder, MD, FACEP, FAAEM
  Senior Vice President and CMO
  Baltimore Washington Medical Center
- David Meyer, MD
  Corporate Vice President of Quality and safety
  MedStar Health
- Sherry Perkins, PhD, RN, COO and CNO
  Anne Arundel Medical Center
- Steve Ports, Principal Deputy Director
  Health Services Cost Review Commission
- James R. Rost, MD, Medical Director, NICU and Medical Director of Patient Safety
  Shady Grove Adventist Hospital
- Fredia S. Wadley, MD, President & CEO
  Quality Health Strategies
- Kathleen White, PhD, RN, NEA-BC, FAAN,
  Associate Professor,
  The Johns Hopkins University School of Nursing

Maryland Patient Safety Center

Strategic Priorities

Vision - *Who we are*
A center of patient safety innovation, convening providers of care to accelerate our understanding of, and implement evidence–based solutions for, preventing avoidable harm

Mission – *Why we exist*
Making healthcare in Maryland the safest in the nation

Goals - *What will we accomplish*
- Eliminate preventable harm for every patient, with every touch, every time
- Develop a shared culture of safety among patient care providers
- Be a model for safety innovation in other states

Strategic Areas of Focus - *What we will do*

- Prevent Harm and Demonstrate the Value of Safety
- Spread Excellence
- Lead Innovation in New Areas of Safety Improvement

Maryland Patient Safety Center

Appendix I: MPSC Report to HSCRC on FY 2015 Results and FY 2016 Program Plan and Budget Request

Strategic Partners

- **Courtemanche & Associates** - An interdisciplinary healthcare firm that serves healthcare organizations to improve care through compliance with regulatory and accreditation requirements
- **Quantros** - National vendor of adverse event reporting services
- **VHQC** – Maryland state QIO
- **Health Facilities Association of Maryland** - A leader and advocate for Maryland's long-term care provider community
- **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
- **Maryland Ambulatory Surgical Association** - The state 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

FY15 Highlights

- Initiated pilots of the Patient Safety Certification program in two hospitals and one long term care facility
- Initiated pilots of the Caring for the Caregiver program in two hospitals
- Focused education on OB hemorrhage preparation contributing to a decreased rate of OB hemorrhage deaths
- Established a cooperative relationship with new QIO, VHQC
- Maryland Hospital Hand Hygiene Collaborative completed with twelve consecutive months at goal of 90% or greater aggregate compliance
- Kicked off the innovative Improving Sepsis Survival Collaborative focused on decreasing mortality rates for severe sepsis and septic shock
- Decreased falls with injury in participating long term care facilities by 27.3 % (July 2014 - February 2015)

Maryland Patient Safety Center

Appendix I: MPSC Report to HSCRC on FY 2015 Results and FY 2016 Program Plan and Budget Request

FY16 Initiatives: Education Programs

- 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

FY16 Initiatives: Conferences

- The Annual Maryland Patient Safety Center Conference is the Center's signature event; providing awareness, education and the exchange of best practice solutions to a broad-based audience that goes well beyond the Center's usual participants. The annual Medication Safety Conference has become a premier event for the Center concentrating 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

FY16 Initiatives: Patient Safety Certification

- The certification will utilize both traditional classroom instruction and practical application methodology incorporating positive psychology, using the Patient Safety Officer (PSO) as the focal point. This is an institutional certification.
- 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
- Year two funding focuses on evaluation of pilot sites, implementation of positive psychology module and post-pilot curriculum refinements
- Vendor: Courtemanche & Associates

FY16 Initiatives: Caring for the Caregiver

- Provides timely support to healthcare employees who encounter stressful, patient-related events related to the "second victim" situation.
- Objectives:
  - Reduce the number of harmful patient safety incidents
  - Increase patient satisfaction scores
  - Improve worker satisfaction
  - Increase worker retention rates
- Year two funding focuses on evaluation and development of the "peer to peer" training module
- Vendor: Johns Hopkins University School of Medicine / Armstrong Institute for Patient Safety and Quality

FY 16 Initiatives: Hand Hygiene

- Continues work of Maryland Hospital Hand Hygiene Initiative
- Applies successes and lessons learned to long-term care community
- Objectives:
  - ➢Reduction of facility acquired infections leading to increased length of stay and hospital readmissions
- Twenty-four (24) month collaborative ; recruitment April / May of 2015
- Collaboration with VHQC

FY 16 Initiatives: Clean Environment

- Builds upon accomplishments of Maryland Hospital Hand Hygiene Initiative
- Reduction of surface contamination in high touch areas of facility
- Applicable to hospitals, LTC, ASC's and Outpatient facilities
- Objectives:

  Reduce facility acquired infection rates

Vendor: Clean*Health* Environmental, LLC
MDH2E

Appendix I: MPSC Report to HSCRC on FY 2015 Results and FY 2016 Program Plan and Budget Request

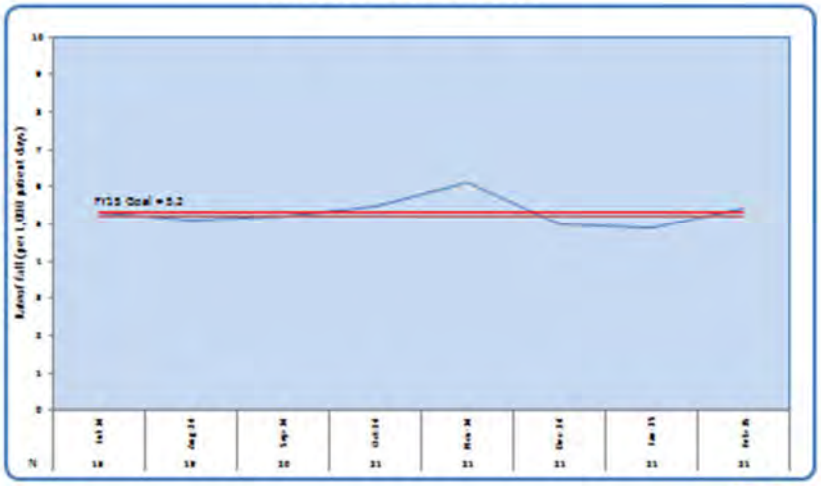
FY16 Initiatives: Safety Initiatives

- Reduction of Falls and Falls with Injury
  - Long-term care with a focus on rate of falls with injury
- Hand Hygiene Initiative
  - Transferring acute care model to ED specific and long-term care in order to reduce preventable infections through better hand hygiene compliance
- Perinatal/Neonatal Learning Network
  - Reduce first time C-sections in singleton, vertex nulliparous women
  - Standardizing care and treatment of neonatal abstinence syndrome
- Sepsis Prevention
  - Reduce mortality due to sepsis through early identification and treatment

Maryland Patient Safety Center

SAFE from FALLS – Long Term Care

Long Term Care Rate of Falls in Participating Facilities
July 2014 to February 2015

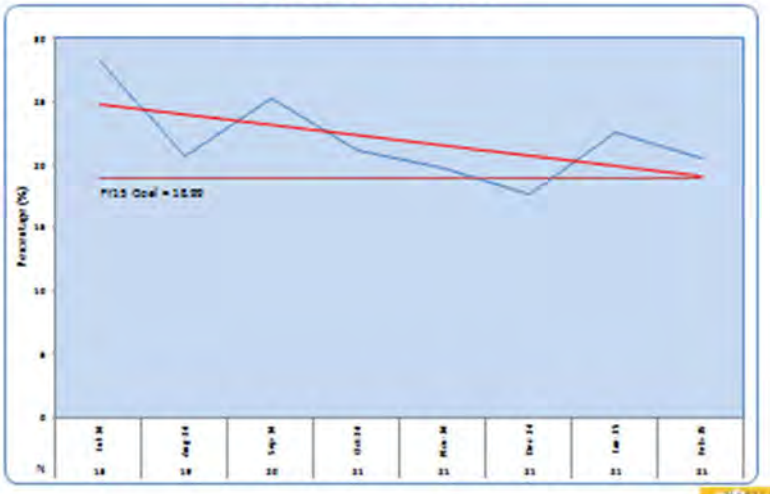


Maryland Patient Safety Center

Appendix I: MPSC Report to HSCRC on FY 2015 Results and FY 2016 Program Plan and Budget Request

SAFE from FALLS – Long Term Care

Rate of Falls with Injury in Participating Facilities
July 2014 to February 2015



Maryland Patient Safety Center

Hand Hygiene

Maryland Hospital Hand Hygiene Aggregate Compliance Rate
October 2010 to October 2014

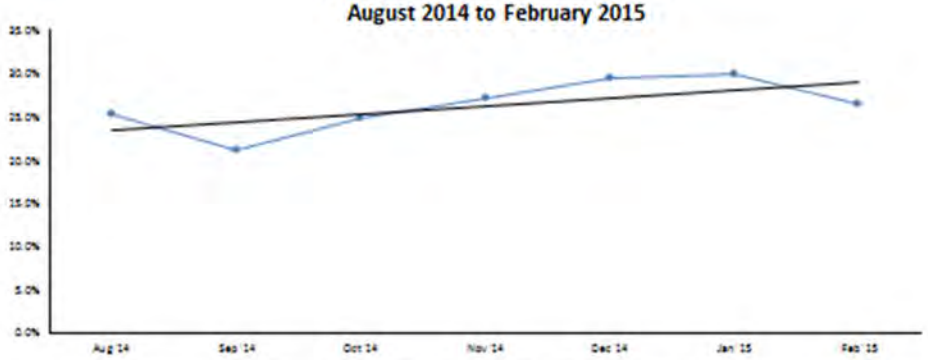
*As of January 1, 2015 bolt and/or Entry HH compliance rate

Maryland Patient Safety Center

Appendix I: MPSC Report to HSCRC on FY 2015 Results and FY 2016 Program Plan and Budget Request

Sepsis

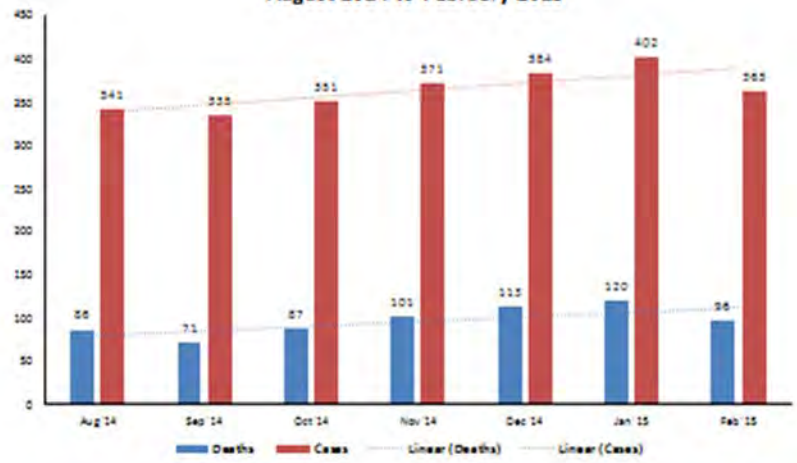
Improving Sepsis Survival Initiative
August 2014 to February 2015



Month-Year	Total Number of Sepsis Patients who expired	Total Number of Sepsis Patients	Sepsis Mortality
Aug-14	86	341	25.22%
Sep-14	71	335	21.19%
Oct-14	87	351	24.79%
Nov-14	101	371	27.22%
Dec-14	115	384	29.43%
Jan-15	120	402	29.85%
Feb-15	96	365	26.45%

Sepsis

Improving Sepsis Survival Initiative
August 2014 to February 2015*



Appendix I: MPSC Report to HSCRC on FY 2015 Results and FY 2016 Program Plan and Budget Request

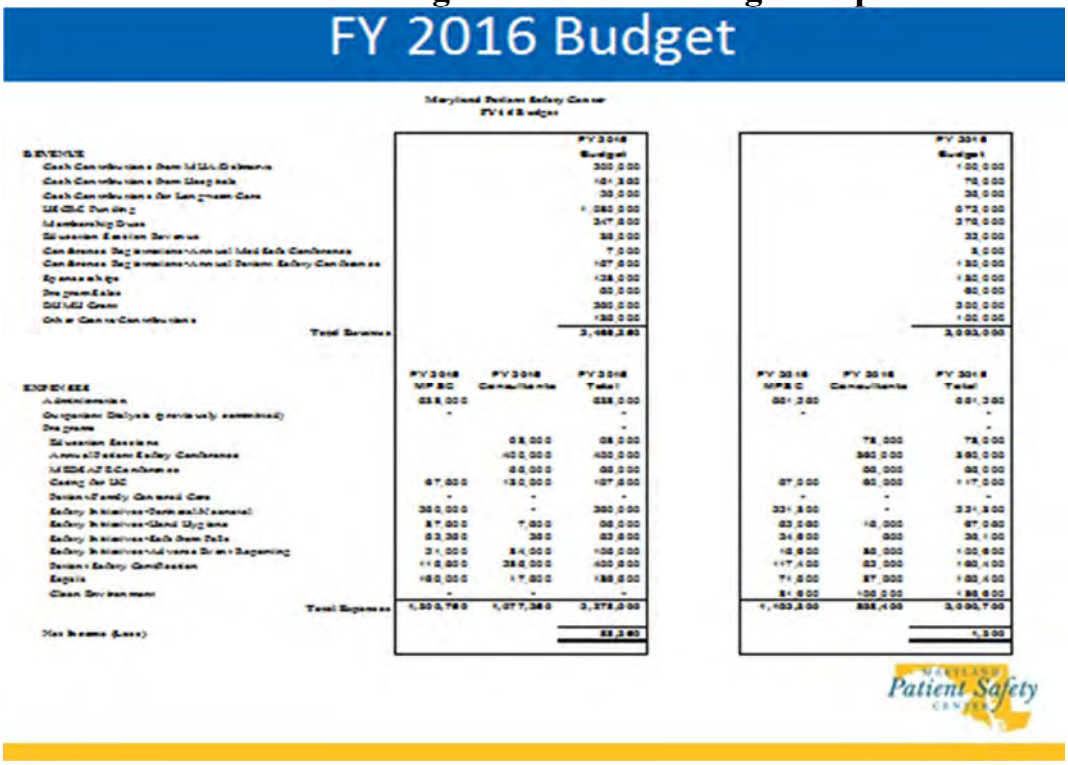
Participants

- Hand Hygiene- 44 Acute Care hospitals and 1 specialty hospital
- Safe from Falls Long Term Care- 21 facilities
- Perinatal/Neonatal Learning Network- all 33 birthing hospitals
- Improving Sepsis Survival- Cohort 1 10 hospitals, Cohort 2 11 hospitals
- Annual Patient Safety Conference 1154 registered

Strategic Direction

- Improve culture of patient safety
- Expand provider involvement
- Supporting provider efforts with regard to Waiver requirements and initiatives
- Continued coordination with statewide healthcare priorities:
  - HSCRC
  - OHQC
  - MHCC
  - DHMH

Appendix I: MPSC Report to HSCRC on FY 2015 Results and FY 2016 Program Plan and Budget Request



Final Staff Recommendation
Radiation Therapy RVUs

June 10, 2015

The Commission staff recommends that the Commission approve revisions to the Relative Value Unit (RVU) Scale for Radiation Therapy services. The revisions are specific to Chart of Accounts and Appendix D of the Accounting and Budget Manual. These revised RVUs were developed by a sub-group of the Maryland Hospital Association's HSCRC Technical Issues Task Force. The sub-group's membership included representatives of the Radiation Therapy departments of many of the Maryland hospitals.

The RVU scale was updated to reflect new additions to the Current Procedural Terminology (CPT) codes; to reflect changes in clinic practices; and to eliminate the reporting of "By Report" to ensure standardized charging practices for RAT services. The proposed changes were sent to all hospitals for comment. The comment period closed on May 28, 2015 with no comments received. 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, 2015.

SECTION 200

CHART OF ACCOUNTS

7360 Radiation- Therapeutic

Function

This cost center provides radiation therapy services as required for the care and treatment of patients under the direction of a qualified radiation oncologist. Therapeutic radiology services include consultation, patient education, physician planning, simulation, dosimetry planning, blocking and shaping, quality assurance, treatment delivery, image guidance, on-treatment assessment, and follow-up. Therapeutic radiation may be delivered using a variety of radiation sources including external photon beams, external live radiation source, intracavitary live radiation source, implantable live radiation source, intraoperative radiation, and particle beam therapy. The most common radiation therapy modalities include but are not limited to 3-D conformal treatment ("3-D"), Intensity Modulated Radiation Therapy ("IMRT"), Image Guided Radiation Therapy ("IGRT"), Stereotactic Radiosurgery ("SRS"), Stereotactic Body Radiation Therapy ("SBRT"), brachytherapy, and intraoperative radiation therapy ("IORT"). Details and descriptions of radiation therapy services and terminology can be found on the websites of the Centers for Medicare and Medicaid Services, the National Cancer Institute, and the American Society for Radiation Oncology.

Description

This cost center includes the direct expenses incurred in providing therapeutic radiology services. Included in these direct expenses are: salaries and wages, employee benefits, professional fees (non-physician), supplies, purchased services, maintenance costs (maintenance contracts or bio-medical engineering costs if done in-house) on principal equipment, facility costs, other direct expenses, and transfers.

Standard Unit of Measure: Relative Value Units

Therapeutic Radiology RVUs were assigned using the 2015 CMS Physician Fee Schedule, technical component or global RVUs. The RVU Assignment Protocol is detailed in the Appendix D Standard Unit of Measure References, account number 7360.

Data Source

The number of RVUS shall be the actual count maintained by the Therapeutic Radiology cost center.

Reporting Schedule

Schedule D – Line D34

APPENDIX D

STANDARD UNIT OF MEASURE REFERENCES

Account Number	Cost	Center Title
7360	Radiology	Therapeutic

Approach

Therapeutic Radiology Relative Value Units were developed by an industry task force under the auspices of the Maryland Hospital Association. The descriptions of codes in this section of Appendix D were obtained from the 2015 edition of the Current Procedural Terminology (CPT) manual and the 2015 edition of the Healthcare Common Procedure Coding System (HCPCS). In assigning RVUs the group used the 2015 Medicare Physician Fee schedule (MPFS). RVUs were assigned using the following protocol ("RVU Assignment Protocol").

The RVUs reported in the 2015 MPFS include 2 decimal points. In order to maintain whole numbers in Appendix D, while maintaining appropriate relative value differences reported in the MPFS, the RVU work group agreed to remove the decimals by multiplying the reported RVUs by ten and then rounding the product of the calculation, where values less than X.5 are rounded down and all other values are rounded up.

1. CPT codes with RVUs listed in the MPFS.
    a. For CPT codes with RVUs that include both professional (modifier 26) and technical (modifier TC) components, use only the technical (TC) component RVU.
    b. CPT codes with only a single RVU listed
        a. CPT codes that are considered technical only (such as treatment codes), the single RVU reported will be used.
        b. CPT codes considered professional only (such as weekly treatment management and physician planning), are not listed in Appendix D.
2. CPT codes that do not have RVUs listed in the MPFS.
        a. CPT 77387 did not have a published RVU in the MPFS. The RVU work group agreed the work activity associated with this code is similar to CPT 77014. Given the similarity of the work activity, it was determined the same RVU should be applied to CPT 77387.
        b. CPT codes 77424 and 77425 did not have published RVUs in the MPFS. The RVU work group agreed the work activity associated with these codes is similar to CPT 77787. Given the similarity of the work activity, it was determined the same RVU should be applied to CPTs 77424 and 77425.
        c. CPT 77520 did not have a published RVU in the MPFS. The code does have an OPPS APC relative value weight, and it is valued the same as CPTs 77385 and 77386. It was determined the RVUs for 77385 and 77386 should be applied to CPT 77520.
        d. CPT 77522, 77523, and 77525 did not have published RVUs in the MPFS. These codes are in the same family of services as CPT 77520. The codes have an OPPS APC with a relative value weight 2.112 times greater than the APC for CPT 77520. It was determined CPT codes 77522, 77523, and

77525 should each have the same RVU which is calculated by multiplying 2.112 to the RVU of CPT 77520.

e. CPT 77402 did not have a published RVU in the MPFS. This is a code where Medicare's hospital based fee schedule and physician fee schedule differ. Since the 2015 MPFS is being used as the source for RVUs, the corresponding CPT value is G6003. The RVU work group used the same RVU for G6003 for CPT 77402.

f. CPT 77407 did not have a published RVU in the MPFS. This is a code where Medicare's hospital based fee schedule and physician fee schedule differ. Since the 2015 MPFS is being used as the source for RVUs, the corresponding CPT value is G6007. The RVU work group used the same RVU for G6007 for CPT 77407.

g. CPT 77412 did not have a published RVU in the MPFS. This is a code where Medicare's hospital based fee schedule and physician fee schedule differ. Since the 2015 MPFS is being used as the source for RVUs, the corresponding CPT value is G6011. The RVU work group used the same RVU for G6011 for CPT 77412.

h. CPT 77371 did not have a published RVU in the MPFS, and it was determined there was not a similar CPT for benchmarking. Table 1 provides the methodology employed to assign RVUs of 378 to CPT 77371.

Table 1: CPT 77371 RVU Assessment

CPT 77371 Gamma Knife Treatment Delivery RVU Assignment

a. Step One, Determine a base CPT: CPT 77385 and 77386 were used as a base to which the work associated with CPT 77371 could be compared and extrapolated. CPT 77385 and 77386 each have a RVU of 11.15

b. Step Two, Determine the comparative work components for the CPT in question (77371). These are the work components for which the relative workload will be evaluated against the base CPTs 77385 and 77386.

Component	Weighting	Weighting Methodology
Initial Set-up	65%	The setup for SRS treatment is 4Xs the work effort of an IMRT setup - criticality of coordinate system - application of frame
Treatment	20%	It takes on average 3Xs the amount of time to deliver an SRS Cobalt Based treatment vs. IMRT
QA	7.50%	The QA process is 50% less work effort than with IMRT
Resources	7.50%	The treatment delivery is managed by the Medical Physics personnel as compared to therapists for IMRT delivery. Physicists are 2Xs the resource intensity as IMRT therapists

c. Step Three, Extrapolate the RVU value

	Initial S/U	Treatment	QA	Resources			
Weighting	65%	20%	7.50%	7.50%			
Base RVU	11.15	11.15	11.15	11.15			
Multiplier	4	3	0.5	2	**Sum**	**Multiplier**	**RVUs**
Total RVUs	28.99	6.69	0.42	1.67	**37.77**	**10**	**378**

3. CPT codes for which the published RVU did not make sense,
    a. CPT 77333 had a RVU that did not seem reasonable as compared to CPT 77332 and 77334, which are in the same family of codes and clinical services. It was determined the RVU for CPT 77333 should be the average value of CPT codes 77332 and 77334.

CPT Codes without an Assigned RVU Value

An effort was made to assign RVUs to all codes that were effective in 2015. In the case of CPT codes listed as 'By Report', hospitals should assign RVUs based on the time and resource intensity of the service provided compared to like services in the department.

For new codes developed and reported by CMS after the 2015 reporting, these codes are considered to be "By Report". When assigning RVUs to these new codes, hospitals should use the RVU Assignment Protocol described above where possible. Documentation of the assignment of RVUs to codes not listed in Appendix D should always be maintained by the hospital.

CPT Code	Procedure	RVU
~~61793~~	~~Stereotactic Focused Proton Beam or Gamma Radiosurgery~~	~~175~~
~~——~~	~~Reset/set Treatment Field – The redefining a previously simulated field~~	~~6~~
77014	Computed tomography guidance for placement of radiation therapy fields	20
77280	Therapeutic radiology simulation-aided field setting; simple	66
77285	Therapeutic radiology simulation-aided field setting; intermediate	104
77290	Therapeutic radiology simulation-aided field setting; complex	120
77293	Respiratory motion management (list separately in addition to code for primary procedure)	101
77295	3-Dimensional radiotherapy plan, including dose-volume histograms	74
77299	Unlisted procedure, therapeutic radiology clinical treatment planning	By Report
77300	Basic radiation dosimetry calculation, central axis depth dose, TDF, NSD, gap calculation, off axis factor, tissue inhomogeneity factors, calculation of non-ionizing radiation surface and depth dose, as required during course of treatment, only when prescribed by the treating physician	9
77301	Intensity modulated radiotherapy plan, including dose-volume histograms for target and critical structure partial tolerance specifications	425
~~77305~~	~~Teletherapy, isodose plan (whether hand or computer calculated); simple (one or two parallel opposed unmodified ports directed to a single area of interest)~~	~~15~~
77306	Teletherapy isodose plan; simple (1 or 2 unmodified ports directed to a single area of interest), includes basic dosimetry calculation(s)	20
77307	Teletherapy isodose plan; complex (multiple treatment areas, tangential ports, the use of wedges, blocking, rotational beam, or special beam considerations), includes basic dosimetry calculation(s)	37
~~77310~~	~~Intermediate (three or more treatment ports directed to a single area of interest)~~	~~20~~
~~77315~~	~~Complex (mantle or inverted Y, tangential ports, the use of wedges, compensators, complex blocking, rotational beam or special beam considerations)~~	~~30~~
77316	Brachytherapy isodose plan; simple (calculation[s] made from 1 to 4 sources, or remote afterloading brachytherapy, 1 channel), includes basic dosimetry calculation(s)	32
77317	Brachytherapy isodose plan; intermediate (calculation[s] made from 5 to 10 sources, or remote afterloading brachytherapy, 2-12 channels), includes basic dosimetry calculation(s)	41

77318	Brachytherapy isodose plan; complex (calculation[s] made from over 10 sources, or remote afterloading brachytherapy, over 12 channels), includes basic dosimetry calculation(s)	56
77321	Special teletherapy port plan, particles, hemibody, total body	12
~~77326~~	~~Brachytherapy isodose calculation; simple (calculation made from single plane, one to four sources/ribbon application, remote afterloading brachytherapy, 1 to 8 sources)~~	~~20~~
~~77327~~	~~Intermediate (multiplane dosage calculations, application involving 5 to 10 sources/ribbons, remote afterloading brachytherapy, 9 to 12 sources)~~	~~25~~
~~77328~~	~~Complex (multiplane isodose plan, volume implant calculations, over ten sources/ribbons used, special spatial reconstruction, remote afterloading brachytherapy, over 12 sources)~~	~~35~~
77331	Special dosimetry (e.g., TLD, microdosimetry) (specify), only when prescribed by the treating physician	5
77332	Treatment devices, design and construction; simple~~, to include prefabricated blocks~~ (simple block, simple bolus)	15
77333	Treatment devices, design and construction; intermediate, ~~to include prefabricated blocks~~ (multiple blocks, stents, bite blocks, special bolus)	20
77334	Treatment devices, design and construction; complex (irregular blocks, special shields, compensators, wedges, molds or casts)	25
77336	Continuing medical ~~radiation~~ physics consultation, including assessment of treatment parameters, quality assurance of dose delivery, and review of patient treatment documentation in support of therapeutic radiologist, ~~including continuing quality assurance~~ reported per week of therapy	21
77338	Multi-leaf collimator (MLC) device(s) for intensity modulated radiation therapy (IMRT), design and construction per IMRT plan	79
77370	Special medical radiation physics, consultation	32
77371	Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cranial lesion(s) consisting of 1 session; multi-source Cobalt 60 based	378
77372	Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cranial lesion(s) consisting of 1 session; linear accelerator based	297
77373	Stereotactic body radiation therapy, treatment delivery, per fraction to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions	377
~~77375~~	~~3D Reconstruction of the Tumor~~	~~204~~
77385	Intensity modulated radiation treatment delivery (IMRT), includes guidance and tracking, when performed; simple	112
77386	Intensity modulated radiation treatment delivery (IMRT), includes guidance and tracking, when performed; complex	112

77387	Guidance for localization of target volume for delivery of radiation treatment delivery, includes intrafraction tracking, when performed	20
77399	Unlisted procedure, medical radiation physics, dosimetry and treatment devices	By Report
77401	Radiation treatment delivery, superficial and/or ortho voltage, per day	6
77402	Radiation treatment delivery, ~~single treatment area, single port or parallel opposed ports, simple blocks or no blocks; up to 5 MeV~~ >1 MeV; simple	45
~~77403~~	~~6–10 MeV~~	~~6~~
~~77404~~	~~11–19 MeV~~	~~7~~
~~77406~~	~~20 MeV or greater~~	~~8~~
77407	Radiation treatment delivery~~, two separate treatment areas, three or more ports on a single treatment area, use of multiple blocks; up to 5 MeV~~ >1 MeV; intermediate	72
~~77408~~	~~6–10 MeV~~	~~7~~
~~77409~~	~~11–19 MeV~~	~~8~~
~~77411~~	~~20 MeV or greater~~	~~9~~
77412	Radiation treatment delivery, ~~three or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, special particle beam (e.g., electron or neutron); up to 5 MeV~~ >1 MeV; complex	77
~~77413~~	~~6–10 MeV~~	~~9~~
~~77414~~	~~11–19 MeV~~	~~10~~
~~77416~~	~~20 MeV or greater~~	~~11~~
77417	Therapeutic radiology port film(s)	3
77422	High energy neutron radiation treatment delivery; single treatment area using a single port or parallel-opposed ports with no blocks or simple blocking	9
77423	High energy neutron radiation treatment delivery; 1 or more isocenter(s) with coplanar or non-coplanar geometry with blocking and/or wedge, and/or compensator(s)	18
77424	Intraoperative radiation treatment delivery, x-ray, single treatment session	147
77425	Intraoperative radiation treatment delivery, electrons, single treatment session	147
77470	Special treatment procedure (e.g., total body irradiation, hemibody irradiation, per oral, vaginal cone irradiation)	13
74999	Unlisted procedure, therapeutic radiology treatment management	By Report
77520	Proton treatment delivery, simple, without compensation	112
77522	Proton treatment delivery, simple, with compensation	235
77523	Proton treatment delivery, intermediate	235

77525	Proton treatment delivery, complex	235
77600	Hyperthermia, externally generated; superficial (i.e., heating to a depth of 4 cm or less)	90
77605	Hyperthermia, externally generated; deep (i.e., heating to depths greater than 4 cm)	183
77610	Hyperthermia generated by interstitial probe(s); 5 or fewer interstitial applicators	266
77615	Hypothermia generated by interstitial probe(s); more than 5 interstitial applicators	252
77620	Hyperthermia generated by intracavitary probe(s)	105
77750	Infusion or instillation of radioelement solution	31
77761	Intracavitary ~~radioelement~~ radiation source application; simple	53
77762	Intracavitary radiation source application; intermediate	61
77763	Intracavitary radiation source application; complex	79
77776	Interstitial ~~radioelement~~ radiation source application; simple	64
77777	Interstitial radiation source application; intermediate	54
77778	Interstitial radiation source application; complex	80
~~77781~~	~~Remote afterloading high intensity brachytherapy; 1-4 source positions or catheters~~	~~60~~
~~77782~~	~~5-8 source positions or catheters~~	~~70~~
~~77783~~	~~9-12 source positions or catheters~~	~~80~~
~~77784~~	~~Over 12 source positions or catheters~~	~~90~~
77785	Remote afterloading high dose rate radionuclide brachytherapy; 1 channel	46
77786	Remote afterloading high dose rate radionuclide brachytherapy; 2-12 channels	90
77787	Remote afterloading high dose rate radionuclide brachytherapy; over 12 channels	147
77789	Surface application of ~~radioelement~~ radiation source	17
77790	Supervision, handling, loading of ~~radioelement~~ radiation source	12
77799	Unlisted procedure, clinical brachytherapy	By Report

Nurse Support Program II

Competitive Grant Review Panel Recommendations

For FY 2016

Health Services Cost Review Commission

4160 Patterson Avenue, Baltimore, MD 21215

June 10, 2015

This is a final recommendation for Commission consideration at the June 10, 2015 Public Commission Meeting.

INTRODUCTION

This recommendation summarizes the funding recommendation of the Nurse Support Program II (NSP II) Competitive Grant Review Panel for FY 2016. It also provides a report on the activities of the NSP II Workgroup, formed as part of the recommendations of the NSP II Outcomes Evaluation report for FY 2006- FY 2015, as approved on January 14, 2015 by the HSCRC Commission. With guidance from the Workgroup, NSP II has undergone a reconfiguration with new initiatives to meet NSP II goals, and strengthened requirements for standardized data.

BACKGROUND

Since the mid-1980's, the Health Services Cost Review Commission has funded programs to address the cyclical nursing workforce shortages. The Nurse Education Support Program evolved, first into the hospital based NSP I program in 2001 and then into the nursing education based NSP II program in 2005. Over the last decade, the NSP I and NSP II programs worked in parallel pathways along separate tracks to ensure nursing personnel and services were available to improve health and health care in Maryland. Although they were not at cross purposes, but they weren't necessarily working together. Since the 2012 NSP I Evaluation Report, the staff increasingly looked for opportunities for these two programs to collaborate in meeting joint recommendations and objectives.

PROGRAM EVALUATION

Over the last year, a summative program evaluation was completed by the HSCRC and Maryland Higher Education Commission (MHEC) staff for the Nurse Support Program II. The program outcomes, nursing graduate data and current condition of the nursing workforce were reviewed. The HSCRC approved a continuation of the NSP II for an additional five years, FY 2016 to FY 2020, at the same funding levels of up to 0.1% of hospital regulated gross patient revenue, for nursing education capacity and faculty focused NSP II programs. The final report on a decade of funded programs is available in the January 14, 2015 HSCRC Commission minutes at NSP II Evaluation Report .

NOTABLE PROGRAM OUTCOMES

Over 5,800 or 27% of 20,967 total Maryland new pre-licensure nurse graduates can be directly tied to NSP II Competitive Institutional Grant program outcomes from 2006-2014.

- *New Nursing Faculty Fellowships* resulted in the recruitment and retention of 245 new faculty members (lecture and clinical) at 12 universities and 7 community colleges. Forty-four percent (44%) were from underrepresented groups in nursing. The retention of new full-time faculty is 88%.
- Bachelor degree program (BSN) enrollments were 4,086 in 2005 rising to 6,832 in 2013, a 67% increase. Associate degree (ADN) enrollments rose 27% from 9,507 in 2005 to 12,971 in 2013 with assistance from NSP II programs.
- BSN graduates steadily increased from 1,127 graduates in 2006 to 1,615 graduates in 2013. ADN graduates steadily increased from 1,090 in 2006 to 1,726 graduates in 2013.
- The number of new pre-licensure nurse graduates passing the National Council Licensure Examination for Registered Nurses (NCLEX-RN) exam on the first attempt has steadily increased from 1,566 in 2005 to 2,598 in 2013.

According to the U.S. Department of Health and Human Services Health Resources and Services Administration (HRSA) report, the Maryland nurse workforce increased 38% from 2008 through 2012. Nationally, the increase was 28%. Even with these gains, Maryland is one of 16 states projected to have a significant shortfall of RNs by 2025 (HRSA, 2014).

NSP II WORKGROUP

The NSP II Workgroup (WG) was formed in direct response to 2 of the 5 key recommendations presented in the evaluation report. Over the course of eight weeks, the NSP II Workgroup met regularly to accomplish the group's mission of completing written guidance for competitive institutional grants and statewide initiatives for the next five years of NSP II funding. Within that framework, the group attempted to envision nursing education through a hospital lens.

The WG included several Chief Nursing Officers at hospitals, a physician HSCRC Commissioner, hospital industry partners, nursing professionals and nursing faculty across the

state. Deans and Faculty leaders broadly represented the state's nursing degree programs; with community colleges and universities from western Maryland and the Eastern Shore, the centrally located historically black institutions, as well as public and private universities. The state's nursing professional organizations, state regulatory bodies and staff at HSCRC and MHEC completed the WG's team.

During the 2 months, several meetings were held at HSCRC offices with interim conference calls. Survey results, suggested definitions, and data elements were shared by email with WG members. Guidance from the Maryland Action Coalition, Maryland Deans and Directors Groups, Maryland Nurses Association, Maryland Board of Nursing, Maryland Hospital Association, Maryland Organization of Nurse Executives and Nurse Residency Consortium is reflected in the future NSP II programs. When all recommendations were complete, minutes of all WG meetings were submitted to HSCRC staff..

During work sessions, members quickly recognized the potential for synergy if the NSP I and II programs were moving forward on the same track. By joining nurses in practice and academia, swifter progress toward shared goals can be expected. The implementation of improvements and evaluation of impact on patient care and systems of care can be considered from this broader perspective of nurse leaders across the spectrum. Several new programs developed by the WG for the next five years of NSP II will be inclusive of NSP I hospital based nursing practice participants and NSP II academic based nursing faculty participants.

POINTS OF CONSIDERATION

Some significant points from the WG discussions included new models of care, increasing needs of hospitals for educators, better data development, updated articulation agreements, clinical simulation, leadership opportunities, and new partnerships for NSP I and II. With the changing need for nurses in new roles and transitions of care models, defining these new positions in standardized language is important. This led to the hospital nurse educator survey completed by Maryland Hospital CNOs , whom reported 8 different job titles. Nurse educators, regardless of title, are needed in higher education institutions and hospitals. The service obligation component of the NSP II Hal and Jo Cohen Graduate Nurse Faculty Scholarship Program will be extended to include hospital, as well as academic educator positions.

Although there is clear agreement on the critical importance of care coordination, the WG recognized the barriers of having nurses prepared to teach these new skills and deliver new transitional care services. As our physician member noted, hospital does not mean inpatient alone, since 25% to 33% of hospital business is in outpatient services. Smooth transitions of care are the key to reducing unnecessary readmissions and containing costs with the global budgets.

It will be challenging to evaluate programs without better data. The group requested Academic Deans/Directors' input on a data dictionary with agreed upon definitions based on readily available and clean sources of data. The NSP II Required Data Set for all proposals and future interim and final reports was developed to address the need for workforce and program evaluation data.

Implementing academic credits for nurse residencies and advancing seamless academic progression with dual enrollments across associate and baccalaureate programs cannot proceed until outdated items in the 30 year old Maryland Articulation Agreements are updated. Nurse leaders representative of Deans, Directors, Maryland Organization of Nurse Executives, Maryland Action Coalition and Maryland Nurses Association will expedite solutions.

Clinical simulation and leadership opportunities are important to both academic and clinical practice nurse leaders. Any future activities should be inclusive to build opportunities for joint projects to address patient outcomes through better care and better health at lower cost. This became the impetus to have these opportunities funded through the NSP II Statewide Initiatives to make resources available to nurses at hospitals and higher education institutions.

Active engagement and participation in dissemination activities is expected from grantees in programs funded by NSP II. The IOM *Future of Nursing* (2010) report is a blueprint for the state's organizations, institutions, hospitals and partners to meet mutual goals. Mechanisms are in place at the Maryland Action Coalition and Maryland Organization of Nurse Executives Nurse Residency Consortiums for NSP II Grant participants to disseminate models and best practices for greater impact across the state.

NSP II FY 2016 RFA

The FY 2016 Competitive Institutional Grants Request for Applications (RFA) is the product of the NSP II Workgroup. The recommendations from the NSP II Evaluation included forming a WG to provide goals and metrics for the NSP II to meet IOM Goals #4, 5, 6, & 7. The

WG completed their task with a new application format, required data elements, goals and objectives focused on the IOM recommendations in a design that is more inclusive of practice and academia partnerships. Methods to meet the recommendations to increase the proportion of nurses with a BSN to 80% by 2020, double the number of nurses with a doctorate by 2020, ensure that nurses engage in lifelong learning, and prepare and enable nurses to lead change to advance health are embedded throughout the guidelines for the next five years of the NSP II programs.

The RFA includes a section on statewide initiatives and describes two additions to the existing individual faculty focused graduate scholarships, faculty fellowships and doctoral grants. The new statewide initiatives for individuals are the Clinical Simulation Resource Consortium (CSRC) and the Leadership Consortium for Nursing Practice and Education (LC). Both of these were built on successful models funded by NSP II in prior grant rounds. The lead institutions had previous grants and agreed to administer five years of programs for faculty and clinical practice nurses. These are statewide programs to fund leadership and simulation learning, practice and growth opportunities.

In addition, the RFA included an opportunity for successful programs to be replicated. The Eastern Shore-Faculty Academy and Mentoring Initiative (ES-FAMI II) continuation grant builds on an earlier funded NSP II project with successful faculty outcomes. There are 50 Academy graduates with 38% from male and/or ethnic/racial minority backgrounds who can be accessed through an electronic database by partner schools or hospitals seeking clinical instructors. The project has attracted national and international attention, with presentations and publication in several peer reviewed journals recognizing the funding support of NSP II. It is one model for a clinical academic practice partnership between universities, community colleges, hospitals and health systems to ensure a pool of qualified nursing instructors are available to serve all partners.

KEY MESSAGES

The IOM's (2010) *Future of Nursing, Leading Change, Advancing Health* goals and recommendations were adopted by both NSP I and NSP II during evaluations completed in 2012 and 2015. The key messages for preparing nurses to lead change included stronger leadership preparation through formal programs to develop existing and emerging leaders, mentorship and

involvement in policy making, especially for the critical areas of quality and patient safety. The key messages for transforming nursing education included higher levels of education through seamless academic progression, participation in inter-professional education, opportunities for clinical simulation in education, encouraging younger nurses to pursue faculty careers through doctoral preparation and workforce planning for nurses to be prepared to meet the future needs of patients. The key messages for practice are providing nurse residencies to reduce turnover rates of new nurse graduates and increasing involvement in designing, implementing and using electronic health records and decision pathways to streamline care, reduce complications and improve patient experiences. Using technology to make health care delivery safer, more efficient, and accessible helps nurses deliver patient centered care that is well coordinated.

The progress towards these Nurse Support Program state level goals, based on the IOM (2010) *Future of Nursing* report's national goals, will be measured as part of the next program evaluation of NSP I in 2016-17 and for NSP II in 2019-20.

FINDINGS AND RECOMMENDATION: NSP II COMPETITIVE INSTITUTIONAL GRANTS FOR FY 2016

For FY 2016, the NSP II Competitive Grants Review Panel received 27 proposals. The seven-member Evaluation Review Panel comprised of hospital nursing administrators, former NSP II grant project directors, retired nursing educators, current NSP I project directors, licensure and policy leaders along with MHEC and HSCRC staff reviewed all proposals. All proposals were received by the deadline and followed the guidelines for submission, so the panel scored each proposal following the rubric in the FY 2016 RFA. After the panel convened for full discussions, a consensus developed around the most highly recommended proposals. Therefore, the Review Panel recommended funding for 23 of 27 requests that ranged from one year planning grants to five year full implementation awards totaling $15,737,431. See Table 1 for a listing of the recommended grant awards for FY 2016.

The most highly recommended proposals were representative of innovative programs leading off with the *Advancing Nursing and Allied Health with Inter-professional Learning Teams* at The Community College of Baltimore County, followed closely by the planning grant at Chesapeake College for *The Nursing Pathways Option* and equally highly recommended was *Supporting Professional Advancement in Nursing (SPAN)* program at Johns Hopkins University.

Overall, the commitment of NSP II continued to fund proposals with a high likelihood of measurable results with realistic budgets. The funded proposals extended across the state and addressed underrepresented groups in nursing. The following recommendations for both Competitive Institutional Grants and Statewide Initiatives include 16 schools of nursing which are inclusive of 7 community colleges, 2 private universities, 3 HBCUs and 4 public universities.

The new Statewide Initiatives for leadership and clinical simulation opportunities for hospital and academic educators and leaders were developed under the guidance of the WG. The opportunity to continue successful programs funded by NSP II as statewide resources was another improvement recommended by the WG. The aim was to provide stable funding for five years for institutions with the background and technological support to provide these important programs that meet IOM objectives. All three initiatives were highly endorsed by the Review Panel. These new iterations of successful programs were recommended for funding as resources for nurses involved in hospital practice and education, existing and emerging nurse leaders and clinical faculty development. See Table 2 for the list of the new Statewide Initiatives for FY 2016.

The Staff at HSCRC and MHEC wish to extend a special note of thanks to HSCRC Commissioner Jencks and all participants of the 2015 NSP II evaluation team, the Workgroup and the Review Panel. Many devoted professionals representing the health care industry worked together to provide the Commission with the information needed to continue a program with a proven record of success.

STAFF RECOMMENDATIONS

1. The HSCRC and MHEC staff members are recommending that the NSP II Competitive Grant Review Panel recommendations are approved for funding as presented.
2. Due to the timing and process of this review, staff of the HSCRC and MHEC request that this recommendation be waived from the comment rule so that it may become effective on July 1, 2015.

REFERENCES

Institute of Medicine. (2010). *The Future of Nursing: leading change advancing health*. Washington, DC: The National Academies Press.

Nurse Support Program II (NSP II) Outcomes Evaluation FY 2006 – FY 2015, Health Services Cost Review Commission, January 14, 2015 Minutes. http://www.hscrc.state.md.us/documents/commission-meeting/2015/01-14/HSCRC-Post-Commission-Meeting-2015-01-15.pdf

U.S. Department of Health and Human Services, Health Resources and Services Administration, National Center for Health Workforce Analysis. *The Future of the Nursing Workforce: National- and State-Level Projections, 2012-2025.* Rockville, Maryland, 2014. http://bhw.hrsa.gov/healthworkforce/supplydemand/nursing/workforceprojections/nursingprojections.pdf

Table 1: Final Recommendations for funding for FY 2016 Competitive Institutional Grants

Proposal	Name	School of Nursing	Total Award
16-101	Nursing 4.0	Baltimore City CC	$1,403,647
16-102	Nursing Student Success Center	Bowie State	$712,376
16-103	Advancing Nursing and Allied Health w/ IPE Learning Teams	CC of Baltimore County	$141,369
16-105	Leading Academic Nursing (LEARN)	Coppin State	$736,943
16-106	Associate to Bachelors (ATB)	Frostburg State	$1,495,991
16-107	Dual Track- Primary & MH NP	Frostburg State	$252,630
16-108	Collaborative BSN Model	Frostburg State	$710,873
16-110	Accelerated ADN to BSN	Hagerstown CC	$543,879
16-111	Cecil-Harford Academic Progression	Harford CC	$545,676
16-112	Supporting Professional Advancement in Nursing (SPAN)	Johns Hopkins	$1,624,288
16-114	ADN to BSN Pathway	Montgomery College	$1,079,223
16-115	Excellence in Nursing Programs	Morgan State	$766,480
16-116	Improving Success of RN-BSN	Notre Dame	$341,432
16-117	Eastern Shore- Western Shore Faculty Initiatives (ES-WSFI)	Salisbury University	$133,542
16-118	Nursing Degree Completion Initiative	Towson University	$1,658,385
16-119	Statewide Preceptor for APRNs	University of Maryland	$470,659
16-121	Planning Statewide AD to BS/MS	University of Maryland	$247,291
16-122	Academic Credit for Residency	University of Maryland	$165,391
16-123	Preparing 21st Century Nurses Planning	University of Maryland	$101,000
16-124	Faculty Mentorship Program Pilot	University of Maryland	$122,045
16-125	Professional Development of Nursing Faculty and Educators	University of Maryland	$1,457,052
16-126	Center for Nursing Success	Wor-Wic CC	$977,441
16-127	Nursing Pathways Options Planning	Chesapeake	$49,818
		Total	$15,737,431

Table 2: New Statewide Initiatives

Proposal	Name	School of Nursing	Total Award
NSP 603	Clinical Simulation Resource Consortium	Montgomery College	$3,112,107
NSP 703	Leadership Consortium-Practice/Education	University of Maryland	$2,500,000
NSP 803	ES-Faculty Academy and Mentoring II	Salisbury University	$2,098,221
		Total	$7,710,328

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TO: **Commissioners**

FROM: **HSCRC Staff**

DATE: **June 3, 2015**

RE: **Hearing and Meeting Schedule**

July	THE JULY COMMISSION MEETING HAS BEEN CANCELLED
August 12, 2015	To be determined - 4160 Patterson Avenue HSCRC/MHCC Conference Room

Please note that Commissioner's binders will be available in the Commission's office at 11:45 a.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 at http://www.hscrc.maryland.gov/commission-meetings-2015.cfm

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