HEALTH SERVICES COST REVIEW COMMISSION
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487th MEETING OF THE HEALTH SERVICES COST REVIEW COMMISSION
April 11, 2012

EXECUTIVE SESSION
9:15 a.m.

1. **Waiver Issues**
2. **Comfort Order: Johns Hopkins Hospital**
3. **Personnel Issues**

PUBLIC SESSION OF THE
HEALTH SERVICES COST REVIEW COMMISSION
10:00 a.m.

1. **Review of the Executive Session and Public Meeting Minutes of the March 7, 2012 Meeting**

2. **Executive Director's Report**

3. **Docket Status – Cases Closed**

   2149A – Johns Hopkins Health System
   2150A – Johns Hopkins Health System
   2151A – Johns Hopkins Health System
   2152A – Johns Hopkins Health System
   2153N – Anne Arundel Medical Center
   2154A – Johns Hopkins Health System
   2156A – University of Maryland Medical System

4. **Docket Status – Cases Open**

   2155A – University of Maryland Medical System

5. **Draft Recommendations on FY 2013 Update Factor and Waiver Trend Mitigation**

6. **Draft Recommendations on FY 2013 Funding Support for the Maryland Patient Safety Center**

7. **Timeline for Implementation and Goals of an Outpatient Constraint System**

8. **FY 2012 Legislative Session Wrap-up**

9. **Legal Report**

10. **Hearing and Meeting Schedule**

Executive Session Minutes
of the
Health Services Cost Review Commission

March 7, 2012

Upon motion made, Chairman Colmers called the meeting to order at 1:00 p.m.

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

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

Patrick Redmon, Steve Ports, Jerry Schmith, Mary Beth Pohl, and Oscar Ibarra attended representing Commission staff.

Also attending were Leslie Schulman and Stan Lustman, Commission Counsel.

Item One

The Commission discussed issues relating to the status of the waiver and the potential modification of the waiver test.

Item Two

The Commission discussed personnel issues.

The Executive Session was adjourned at 1:42 p.m.

MINUTES OF THE
486th MEETING OF THE
HEALTH SERVICES COST REVIEW COMMISSION

March 7, 2012

Chairman John Colmers called the meeting to order at 1:45 p.m. Commissioners George H. Bone, M.D., Jack C. Keane, Thomas R. Mullen, and Herbert S. Wong, Ph.D. were also present.

REPORT OF THE EXECUTIVE SESSION OF MARCH 7, 2012

Oscar Ibarra, Program Administration & Information Management, summarized the minutes of the March 7, 2012 Executive Session.

ITEM I
EXECUTIVE AND PUBLIC SESSIONS OF FEBRUARY 1, 2012

The Commission voted unanimously to approve the minutes of the February 1, 2012 Executive and Public Sessions.

ITEM II
EXECUTIVE DIRECTOR'S REPORT

Patrick Redmon, Ph.D., Executive Director, discussed the results of Monitoring Maryland Performance (MMP). Dr. Redmon stated that since last month's public meeting, staff has been attempting to determine what is contributing to the rate of growth in charge per case for the twelve months ending December 2011. MMP data showed that the rate of growth in charge per case was 8.8%, which was far above the 4.3% budgeted under last year's update factor discussions. We know that we have initiated several policies that have contributed to this growth, but the increase is much higher than expected. We have continued to see volume declines in admissions for the year, 3.64%, while outpatient revenue increased by 11.8%.

Dr. Redmon indicated that based on the September 2010 waiver letter and preliminary estimates from the actuary for the Center for Medicare and Medicaid Services (CMS), Maryland's estimated relative waiver position as of December 2010 stands at 9.31%. Dr. Redmon stated that the actuary's revised forecast that projects lower case mix growth nationally was further contributing to erosion in the estimated waiver cushion. With the revised numbers, our forecast indicates that Maryland is poised to exceed the cumulative growth of rate of payments per case nationally in FY 2012 by -0.05%, although Maryland would recover to 0.79% in FY 2013. However, our forecast does not include the continued erosion we have seen due to one-day stays or the possible impact of the Admission-Readmission Revenue (ARR) and Total Patient Revenue

(TPR) programs.
Dr. Redmon then reported on the update discussions and where they are leading us in response to the waiver crisis. In that regard, it is useful know the causes of the increase in charge per case in MMP above the budgeted amount. Dr. Redmon noted that: 1) the core update factor of 1.56%; 2) the Medicaid Assessment, 1.90%; 3) shift of revenue from outpatient to inpatient through rate realignment, 1.6%; and 4) seed funding for the ARR and TPR programs, 0.5%. However, the biggest single contributor has been the one-day stay policy which, by excluding one-day cases from the Charge-per Case methodology, left in the charge capacity and encouraged the conversion to outpatient observation cases. Further, two day stay cases also appear to be converting to observation cases. As a consequence, the case mix index for the remaining cases goes up, because the remaining cases are now more expensive on average. The combined impact of the changes related to one-day and two-day cases is approximately 3% of the increase in MMP charge per case for the first half of 2012 versus the first half of 2011.

Dr. Redmon stated that some of the options that we have been discussing in the update discussion for improving the waiver cushion include: 1) reversal of the one-day stay policy with the removal of the rate capacity and measuring case mix growth with the impact of one-day cases; 2) suspending the ARR and TPR programs and further seed funding; 3) increasing the fixed cost percentage of the volume adjustment; and 5) increasing the Medicare and Medicaid differential.

Dr. Redmon reported that CMS staff has discussed with HSCRC staff the Commission's letter describing the HSCRC's efforts to reduce readmissions in Maryland (the ARR and TPR programs) submitted in anticipation of Medicare's requirements for cost and readmission reductions. CMS staff has asked for clarification of the structure of the programs and a demonstration of how the HSCRC's policies would perform as well or better than Medicare's program.

Steve Ports, Principal Deputy Director-Policy & Operations, presented an update on the FY 2013 Medicaid budget deliberations in the legislature relating to Medicaid hospital cost containment measures (See Legislative Update – March 7, 2012).

Mr. Ports noted that bills have been introduced that would create a Medicaid Sustainability Commission whose recommendations on Medicaid funding would have the impact of increasing State general funds for Medicaid by at least the amount of the Medicaid Budget Deficit Assessment.

ITEM III
DOCKET STATUS CASES CLOSED

2146A – Johns Hopkins Health System 2147A - Johns Hopkins Health System
2147N – Mt. Washington Pediatric Hospital

ITEM IV
DOCKET STATUS CASES OPEN

Johns Hopkins Health System – 2149A

On December 6, 2011, Johns Hopkins Health System ("System") filed an application with the HSCRC on behalf of its member hospitals, Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, and Howard County General Hospital (the "Hospitals") for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System requests approval from the HSCRC for participation in a renegotiated global rate arrangement for solid organ and bone marrow transplants with United Resources Networks/Optum Health, a division of United HealthCare Services, for a period of one year beginning December 1, 2011.

Staff recommended that: 1) the requirement that an application be filed 30 days prior to the proposed effective date of an alternative method of rate determination arrangement be waived; and 2) the Hospitals' request be approved for one year beginning December 1, 2011. In addition, staff recommended that the approval be based on the execution of the standard Memorandum of Understanding.

The Commission voted unanimously to approve staff's recommendation. Chairman Colmers recused himself from consideration of this application.

Johns Hopkins Health System – 2150A

On December 6, 2011, Johns Hopkins Health System (the "System") filed an application with the HSCRC on behalf of its member hospitals, Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, and Howard County General Hospital (the Hospitals') for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System requests approval from the HSCRC to continue to participate in a renegotiated global rate arrangement for solid organ and bone marrow transplants with Coventry Transplant Network for one year beginning January 1, 2012.

Staff recommended that: 1) the requirement that an application be filed 30 days prior to the proposed effective date of an alternative method of rate determination arrangement be waived; and 2) the Hospitals' request be approved for one year beginning January 1, 2012. In addition, staff recommended that the approval be based on the execution of the standard Memorandum of Understanding.

The Commission voted unanimously to approve staff's recommendation. Chairman Colmers recused himself from consideration of this application.

Johns Hopkins Health System – 2151A

On December 6, 2011, Johns Hopkins Health System ("System") filed an alternative rate application on behalf of its member hospitals, Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, and Howard County General Hospital (the "Hospitals") requesting approval from the HSCRC to continue to participate in a global rate arrangement with the Canadian Medical Network for cardiovascular procedures and global rates for kidney transplant services and to add bone marrow transplants to the arrangement going forward. The Hospitals request that the Commission approve the revised arrangement for one year beginning December 1, 2011.

Staff recommended that: 1) the requirement that an application be filed 30 days prior to the proposed effective date of an alternative method of rate determination arrangement be waived; and 2) the Hospitals' request be approved for one year beginning December 1, 2011. In addition, staff recommended that the approval be based on the execution of the standard Memorandum of Understanding.

The Commission voted unanimously to approve staff's recommendation. Chairman Colmers recused himself from consideration of this application.

Johns Hopkins Health System – 2152A

On December 6, 2011, Johns Hopkins Health System (the "System") filed an application with the HSCRC on behalf of its member hospitals, Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, and Howard County General Hospital (the Hospitals), requesting approval to continue to participate in a global price arrangement with Aetna Health, Inc. for solid organ and bone marrow transplant services. The Hospitals request that the Commission approve the arrangement for one year beginning January 1, 2012.

Staff recommended that: 1) the requirement that an application be filed 30 days prior to the proposed effective date of an alternative method of rate determination arrangement be waived; and 2) the Hospitals' request be approved for one year beginning January 1, 2012. In addition, staff recommended that the approval be based on the execution of the standard Memorandum of Understanding.

The Commission voted unanimously to approve staff's recommendation. Chairman Colmers recused himself from consideration of this application.

Anne Arundel Medical Center – 2153N

On January 3, 2012, Mount Washington Pediatric Hospital submitted a partial rate application requesting a rate for Electrocardiography (EKG) services. The Hospital requested that the rate

be effective January 1, 2012.

Staff recommended:

1. That COMAR 10.37.10.07 requiring that rate applications be filed 60 days before the opening of a new service be waived;
2. That an EKG rate of $2.89 per RVU be approved effective February 1, 2012; and
3. That the EKG rate not be rate realigned until a full year's experience data have been reported to the Commission.

The Commission voted unanimously to approve staff's recommendation.

Johns Hopkins Health System – 2154A

On February 2, 2012, Johns Hopkins Health System (the "System") filed an application with the HSCRC on behalf of Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center (the "Hospitals") for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System requests approval from the HSCRC for participation in an updated global rate arrangement for cardiovascular procedures with Quality Health Management for a period of one year beginning March 1, 2012.

Staff recommended that: 1) the requirement that an application be filed 30 days prior to the proposed effective date of an alternative method of rate determination arrangement be waived; and 2) the Hospitals' request be approved for one year beginning March 1, 2012. In addition, staff recommended that the approval be based on the execution of the standard Memorandum of Understanding.
The Commission voted unanimously to approve staff's recommendation. Chairman Colmers recused himself from consideration of this application.

University of Maryland Medical Center – 2156A

On February 23, 2012, the University of Maryland Medical Center (the "Hospital") filed an application with the Commission for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The Hospital has requested approval to continue to participate in a global rate arrangement with the Gift of Life Foundation (GOL) for the collection of bone marrow and peripheral blood stem cells from GOL on an outpatient basis, donors to facilitate Hematopoietic Stem Cell transplants into unrelated GOL recipients. The Hospital seeks approval of the arrangement for one year beginning April 1, 2012.

Staff recommended that the Hospital's request be approved for one year beginning April 1, 2012. In addition, staff recommended that the approval be based on the execution of the standard Memorandum of Understanding.

The Commission voted unanimously to approve staff's recommendation.

ITEM V
FINAL RECOMMENDATION REGARDING PROPOSED CHANGES TO NURSE SUPPORT PROGRAM II (NSPII) POLICIES

Mary Pohl, Deputy Director-Research and Methodology, presented the final staff recommendation to modify NSP II statewide initiatives (staff Recommendation "Nurse Support Program II - Statewide Initiatives Modifications" on the HSCRC website). Ms. Pohl noted that there were only minor changes from the draft recommendation presented at the February public meeting.
The modifications for graduate nursing scholarships include: 1) increasing the annual maximum award from $13,000 to the amount of tuition and fees at the applicable institution; 2) removing the time limitations on how many years a scholarship can be awarded (to accommodate students pursuing Doctoral degrees); and 3) authorizing the awarding of Graduate Nursing Scholarships to graduate students pursuing nursing education certificates.

Staff also recommended that: 1) the Maryland Higher Education Commission rebalance the Living Expense Grants component of NSP II by first awarding tuition dollars and subsequently awarding the Living Expense Grants; 3) references to loan repayment assistance be removed from NSP II recommendations; and 3) doctorial dissertation support be authorized under NSP II.

In addition, Ms. Pohl stated that a component of the recommendation was to commemorate Dr. Hal Cohen's ardent support of the nurse support programs in Maryland, and that the Graduate Nursing Faculty Scholarships be named "The Hal and Jo Cohen Graduate Nursing Faculty Scholarship Program." Dr. Cohen's wife Jo and family were in attendance.
Ms. Peggy Dawes, Grant Administrator-MHEC, expressed support for staff's recommendation.

Chairman Colmers stated on behalf of the Commission that the naming of the scholarship program for Dr. Cohen and his wife Jo was a small token to acknowledge the important contribution that Dr. Cohen has made to nursing education over the years.

The Commission voted unanimously to approve staff's recommendation.

ITEM VI
DRAFT RECOMMENDATION ON MEDICARE WAIVER MARGIN TRENDS, DRIVERS, AND OPTIONS

Dr. Redmon presented staff's proposed options that if adopted would improve the waiver cushion and avoid immediate failure. He also expressed staff's desire to work through the update factor to further increase the cushion (See "FY 2012 Options for Improving the Waiver Cushion" on the HSCRC's website). The options recommended were: 1) a revenue neutral shift from inpatient to outpatient by reducing rates in routine patient care centers and increasing rates in

ancillary centers that provide services to both inpatients and outpatients retroactive to January 1, 2012; 2) suspension of the Charge per Visit (CPV) methodology for the current fiscal year; and 3) to include one-day stay cases, at the case specific weight, in the calculation of case mix for purposes of the FY 2012 case mix governor, and recalculate the FY 2011 case mix to determine the impact of excluding case weights for one-day stay cases on revenue growth.

Commissioner Antos asked Dr. Redmon if he would lay out the schedule of decision making, particularly since there will also be update recommendations to come.

Dr. Redmon stated that these proposed actions are to provide immediate waiver cushion relief. This is step one. Staff will present update factor recommendations at the April 2012 public meeting, along with policy decisions associated with the update factor. In addition, there will be recommendations for methodology changes needed to provide longer term waiver cushion relief.

Commissioner Keane stated that we absolutely need a strong outpatient revenue constraint.

Commissioner Bone asked whether there was a down-side risk for the Commission for putting the brakes on the system if later the numbers show that we didn't need to do so.

Chairman Colmers responded that there was no down-side risk. The waiver cushion that we would like to have is 10%. We were below 10% in December of 2010, and we are projected to be at zero in July of 2012.

Public Comments

Michael Robbins, Senior Vice President-Financial Policy for the Maryland Hospital Association (MHA), stated that MHA was committed to working through any technical issues associated with the implementation of any Commission action with staff and more importantly to work with the Commission to ensure that the waiver continues.

Mr. Robbins stressed the need for modernization of the waiver test. In the short term, Mr. Robbins urged the Commission to support legislation establishing a Medicaid Sustainability Commission, which would make recommendations for long term funding for the Medicaid program.

Mr. Robbins offered to share with the Commission an analysis that indicates that there is cost justification for increasing the magnitude of the current Medicare and Medicaid payer differentials. Mr. Robbins suggested that the Commission consider increasing the differentials as part of its short term waiver strategy. Mr. Robbins asserted that such an increase would have a positive effect on the waiver cushion and would decrease Medicaid's reliance on hospital assessments.

Stuart Erdman, Senior Director of Finance and Assistant Treasurer-Johns Hopkins Health System, made a presentation in which he requested that the Commission and the hospital industry initiate a technical review of the accuracy of the Medicare/Medicaid 6% discount. The

discount has not been recalculated in 35 years, and many factors have changed since then. According to Mr. Erdman, it is very likely that the governmental 6% discount is inaccurate. Mr. Erdman noted that MHA's current payment study shows that Medicare paid 23%, or $1 billion, more in Maryland in FY 2010. This situation will only get worse in FY 2011and FY 2012 as the 3% Medicaid Assessment is included in hospital rates. There is no justification to support a Medicare payment differential of 23-26%. According to Mr. Erdman, a simple analysis, using HSCRC data, demonstrates that the Medicare discount must be in the 18-20% range to appropriately balance payments between the governmental and commercial payers. This assumes that Medicare would pay hospital costs, based on HSCRC cost reports, plus its fair share of uncompensated care. Medicaid has essentially adjusted its discount through their assessments on hospitals. The assessment plus the 6% discount translates into an overall discount of approximately 20%. Mr. Erdman stated that this situation needs our full and immediate attention. Unintentionally, enormous payment liability has been inaccurately cost shifted to the government payers and is jeopardizing the Medicare waiver and causing severe Medicaid budget problems.

Barry Rosen, representing United Healthcare, presented comments on staff's recommendations. Mr. Rosen expressed understanding for the need to shift revenue for inpatient to outpatient in order to improve the inpatient waiver test, but he failed to understand why suspending the CPV program helps the waiver at all. Mr. Rosen suggested that over time there should be an overhaul of the outpatient pricing system modeled after Medicare's Outpatient Prospective Payment System. As to the third recommendation, United Healthcare believes there should be case targets and real case mix governors for one-day stay cases. With respect to the Medicare and Medicaid differentials, increasing the differentials would be increasing the cost of obtaining health insurance in Maryland dramatically. Mr. Rosen also suggested the Commission consult its counsel concerning the legality of changing the differentials.

Chairman Colmers expressed his opinion that changing the differential with proper cost justification would not necessarily violate the waiver.

Gary Simmons, Regional Vice President-United Healthcare, commented on some broader issues. According to Mr. Simmons, United Healthcare believes that that it is essential that the update factor for FY 2013 be low, including any adjustment for case mix. Mr. Simmons asserted that the HSCRC should recognize that fixed costs are really more than the 15% of total costs utilized in the volume adjustment factor calculation

Mr. Simmons stated that United Healthcare advocates the imposition of specific requirements on TPR and ARR hospitals to develop criteria for the use of observation services and for discharge planning to prevent readmissions in order to receive an update. Hospitals should also develop 24 hour clinics to reduce emergency room visits. Mr. Simmons suggested that the HSCRC utilize the foregoing of updates in a more comprehensive way to control overall hospital costs.

In addition, United Healthcare suggests that the HSCRC develop more standardized pricing of services among hospitals. United Healthcare believes that more standardization of prices would lead to more efficiency and enhance consumer choice. The concept is that while there are unique aspects in the Maryland system that should be preserved, there are also advantages in

reimbursement systems used outside of Maryland that could be emulated, such as the Medicare Ambulatory Patient Grouping system.

John Hamper, Director-Provider Reimbursement of CareFirst of Maryland, stated that CareFirst supported the staff recommendations but only as an interim step to allow time for the redesign of our reimbursement model, the waiver test, and to realign incentives.

Mr. Hamper urged the Commission to establish some reasonable waiver targets for the next few years. Such targets could be monitored quarterly, and if we fall below the target, the Commission could take necessary actions to bring us back on track.

As to the specifics of the recommendations, Mr. Hamper urged that the modified cost allocations be implemented immediately; that the CPV be suspended for just one year; and that it then be replaced with another outpatient constraint program.

In addition, Mr. Hamper suggested that the Commission consider scaling the results of the ARR program.

Ray Grahe, Vice President, Finance-Meritus Health, expressed support for staff's recommendations. Mr. Grahe noted that reallocating overhead from inpatient to outpatient is analogous to shifting the weight of the update factor from inpatient to outpatient, something with which he is in agreement. Mr. Grahe also supported Mr. Erdman's on reexamining the governmental differential.

Mr. Grahe suggested that the way forward is to reduce incentives for volume. A new expanded waiver test that would look at a per member per month, or a similar measure, would be most appropriate.

Mr. Grahe noted that although hospitals need adequate update factors, saving the waiver is preeminent. Between Medicare and Medicaid, the waiver is worth a billion and a half dollars. Without the waiver there would be chaos. This is a time when we will all have to suffer some pain.

We must reduce unnecessary utilization, and we need to drive the right volumes to the right venues. We need a methodology that aligns physician incentives with hospital incentives. We need methodologies to bundle payments of the hospital and the physician. A start would be to bring payments for physician services provided at the hospital under the jurisdiction of the HSCRC. What is needed is pay-for-performance to provide for payments to physicians in order to align their incentives with those of the hospital. Such arrangements improve quality as well as efficiency.

Commissioner Bone made a motion to approve staff's recommendation.

Commissioner Keane suggested that the Commission wait a month before suspending the CPV program. Mr. Keane also suggested that he believed if the CPV program were suspended, there

would be pressure from the hospital industry not to reinstate an outpatient constraint system especially, as long as the waiver test remains only inpatient.

Dr. Redmon noted that the reason why staff recommended suspending the CPV program is twofold. The first is that there have been significant technical problems with the implementation of the CPV methodology, which continue to hold up the issuance of rate orders for FY 2012. The second is the CPV methodology hasn't worked as a constraint system. According to Dr. Redmon, we basically have to start over and refocus perhaps on a straight forward volume constraint system or possibly a per case constraint on medical supplies and drugs.

The Chairman noted that rate orders with the modified cost allocation to lower inpatient charges and improve the waiver cushion could not be issued expediently if they were required to include the CPV component.

Dr. Redmon answered in the affirmative.

Mr. Keane stated that he would be more comfortable suspending the CPV program immediately if we had a specific commitment to developing a true outpatient constraint system by a particular time.

Commissioner Antos agreed with Mr. Keane that the Commission must set a deadline for implementing a new or revised outpatient constraint system.

Dr. Antos proposed that staff come back at the April public meeting with recommendations for a timetable for the replacement of the CPV program.
Commissioner Keane presented the motion to: 1) waive the normal 60 day comment period; and 2) approve staff's recommendation with the following amendment: "The Commission will suspend the current CPV methodology immediately for all of FY 2012 on the condition that staff come back to the Commission within 6 months with recommendations for a revised or new outpatient constraint system to be put in place not later than in FY 2014. As suggested by Commissioner Antos, and accepted by Commissioner Keane, staff will provide a timetable for developing an interim outpatient constraint methodology for FY 2013 at the April 2012 public meeting. The motion was seconded.

The Commission voted unanimously to approve the amended motion.

ITEM VII
LEGAL REPORT

Regulations

Proposed

Uniform Accounting and Reporting System for Hospitals and Related Institutions – COMAR 10.37.01.02
The purpose of this action is to update the Commission's Manual entitled "Accounting and Budget Manual for Fiscal and Operating Management" (August, 1987), which has been incorporated by reference.

The Commission voted unanimously to forward the proposed regulations to the AELR Committee for review and publication in the Maryland Register.

ITEM VII
HEARING AND MEETING SCHEDULE

April 11, 2012	1:00 p.m., 4160 Patterson Avenue, HSCRC Conference Room
May 2, 2012	Time to be determined, 4160 Patterson Avenue, HSCRC Conference Room

There being no further business, the meeting was adjourned at 3:40 p.m.

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION	*	**COMMISSION**	
UNIVERSITY OF MARYLAND	*	**DOCKET:**	**2012**
MEDICAL CENTER	*	**FOLIO:**	**1965**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2155A**

Staff Recommendation

April 11, 2012

This recommendation was approved at the Commission Meeting on April 11, 2012.

I. INTRODUCTION

The University of Maryland Medical Center ("the Hospital") filed an application with the HSCRC on February 23, 2012 for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The Hospital requests approval from the HSCRC to continue to participate in a global rate arrangement for solid organ and blood and bone marrow transplant services with LifeTrac, Inc. Network for a period of one year, effective April 1, 2012.

II. OVERVIEW OF APPLICATION

The contract will continue to be held and administered by University Physicians, Inc. (UPI). UPI will manage all financial transactions related to the global price contract including payments to the Hospital and bear all risk relating to regulated services associated with the contract.

III. FEE DEVELOPMENT

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

IV. IDENTIFICATION AND ASSESSMENT OF RISK

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

V. STAFF EVALUATION

Staff reviewed the experience under this arrangement for the last year and found it to be unfavorable. The unfavorable experience was related to one case. The Hospital has asserted that the case in question was an anomaly and to ensure against a similar situation arising in the future, the Hospital has re-priced its cases including increasing payments for such outlier cases.

After review of the application and additional information provided by the Hospital, staff believes that the Hospital can achieve favorable performance under this revised arrangement.

V I. STAFF RECOMMENDATION

Staff recommends that the Commission approve the Hospital's application to continue to participate in an alternative method of rate determination for solid organ and blood and bone marrow transplant services with LifeTrac, Inc. for a one year period commencing April 1, 2012. Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospital for the approved contract. This document would formalize the understanding between the Commission and the Hospital, and would include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.

Update Factor Recommendation for FY2013

April 11, 2012

Please direct comments to Patrick Redmon by April 20, 2012 for full consideration. Comments may be sent by mail to 4160 Patterson Avenue, Baltimore, MD 21215 or by email to predmon@hscrc.state.md.us.

DISCUSSION

1. Introduction

Maryland's all payer system was established with specific goals in mind – to provide access to care by funding uncompensated care for hospital, to provide sufficient revenue for efficient and effective hospitals, and to provide that funding with equity across payers. The lynchpin of this system has been the State's Medicare waiver, exempting Maryland from national Medicare payment methodologies and allowing the HSCRC to set rates for all payers – governmental, commercial, and self-pay.

The system is under pressure from a number of factors. Health care reform has altered the concept of efficiency in healthcare. There has been an increasing recognition that true efficiency is not at the level of the hospital discharge but at the level of providing population health. When the existing waiver was developed, the concern was the length of stay within a hospital discharge and the utilization of resources within that stay. Medicare and rate-setting states adopted prospective method payment methods for a hospital stay. These methods using diagnosis related groups (DRGs) established incentives to reduce resource use within a hospital stay, especially by reducing the length of stay for the average discharge.

That emphasis of the 1980s and 1990s has been replaced with recognition that fee-for-service payments incent the utilization of services within each type of care – hospitals, physicians, etc. True efficiency should account for the least expensive method for providing the desired health outcomes while maintaining high levels of quality. The focus of care has shifted from a single discharge to an episode of care across multiple settings or even to the care of a population through prevention of illness and management of disease as the emphasis for efficient care delivery.

In that vein, the HSCRC has begun to adopt methodologies to encourage improved provision of services across settings by reducing preventable readmissions, and by providing capped revenue for hospital services to encourage the provision of care at lower levels of acuity. These initial steps were designed to reduce cost and improve patient care – to positively impact the health of Maryland citizens being served by the State's hospitals. These are the HSCRC's first steps in achieving health care reform's triple aim in Maryland.

These steps are, however, out of sync with the existing waiver with its focus on the average Medicare payment in Maryland versus the nation. While measures to reduce short stays, to reduce readmissions, or to cap revenue for hospital-based services in rural facilities provide incentives to remove cases from inpatient care, the out-migrating cases tend to be the least expensive cases. These policies have increased the payment per case for the remaining cases, including Medicare cases. The consequence has been to erode Maryland's waiver position.

This erosion has come at a time when the State has also experienced extraordinary budgetary pressures. To fund these State expenses for Medicaid, the State has turned to assessments on payers and providers. Because the assessments on hospital rates are part of hospital charges, they too contribute to an increase in Medicare payments per case in Maryland versus the nation.

These changes are creating the perfect storm for Maryland's waiver performance. Our expected performance is described in detail below. The projected rapid deterioration of our waiver position presents an extreme challenge to the future of this system, and dramatic actions are necessary to preserve the system. These options and recommendations are described below in this document.

A question that must be addressed is whether the system is worth saving. What benefits justify the actions needed to preserve this system?

The first benefit lies in the concept of payer equity. While the concept has been stretched with the budgetary pressures faced by the State, the current system still provides the most equitable system of payment across payers in the nation. Markups in Maryland, the difference between costs and charges, were about 27% compared to the average markup of 212% for hospitals nationally in FY 2010. (Hospital assessments have been a major factor in increasing Maryland hospitals' average markup from 22% in FY 2008 to 27% in FY 2010.)This huge difference stems directly from the all-payer system in Maryland, and the requirement that all payers reimburse at rates established by the HSCRC instead of the patchwork of negotiations across payers nationally, with much lower payments from Medicare and Medicaid.

Further, the Maryland citizens have benefited from governmental participation in the all payer system. Because Medicare has paid rates established by the Commission, costs have not been shifted to private payers as in the rest of the nation. Further, Medicaid hospital payments have been matched by the federal government at HSCRC rates, defraying costs to the State, and reducing the costs of the program to private payers, even in the presence of assessments. Hospitals in the State avoid the added administrative burden of negotiating with multiple payers and the disjointed incentives from receiving wildly varying payments from patients receiving similar care.

Additionally, the State does not support public hospitals by providing extensive subsidies to safety net hospitals as in other states. The HSCRC's mechanism for funding uncompensated care has been pivotal to providing access to care for Maryland citizens. State and local governments have also benefited in that the cost of commercial insurance to governmental employers has been reduced in lieu of the shifting that could have occurred in the absence of the waiver. Hospitals have received access to capital markets at lower rates than would otherwise be available in the market because of the stability that the all payer system has provided.

In all, these benefits suggest that immediate actions to preserve the current waiver are worthwhile and necessary. While the State is working with CMS to revise the current waiver, the only arrangement in place at the moment is the existing waiver that is part of current law. Hence, actions to preserve Maryland's waiver status are of the highest priority and are reflected in the staff recommendation for the coming fiscal year.

The goal for this year should be twofold: to preserve the Medicare waiver and to tighten control of the rate-setting system to respond more rapidly to deterioration of the State's expected waiver status. The long-term goal should be waiver modernization to align the incentives faced by the State with the triple aim of healthcare reform – improved quality, improved population health,

and lower growth in the costs of care. The currents efforts toward long-term modernization are described later in this recommendation.

2. Status of the Waiver

Traditionally, staff recommendations have looked at a variety of factors in developing a recommendation for the annual update factor. Factors such as expected inflation for the coming year and the financial condition of hospitals were discussed prominently, and those factors are relevant and must be taken into consideration. However, given the current status of the waiver, the approach in this document is to consider the minimum update factor required to preserve the waiver.

The current waiver test compares the cumulative growth rate in Medicare expenditures per inpatient discharge for Maryland versus the U.S. The State passes the waiver test as long as Maryland's cumulative growth in the Medicare payments per case does not exceed the cumulative growth of payments per case nationally. The base year for this test is 1981, when Maryland's payment per case was $2,971.65, and the nation's was $2,293.09.

In the most recent letter from CMS, Maryland's cumulative growth stood at 324.70% while the nation stood at 363.69% with Maryland at $12,620.50 per Medicare discharge and the nation at $10,632.73 per Medicare discharge. If the nation were to remain unchanged going forward, Maryland payments per discharge could rise by 9.18% before we failed this test. (We refer to this last measure as "the relative waiver test.") These data show our waiver position as of December 2010.

The waiver letters typically lag current events by 15 to 18 months. *Monitoring Maryland Performance* for year ending January 2012 shows that the Charge per Case is growing by 8.91%, far above the 4.3% budgeted under last year's update factor discussions (update factor plus the Medicaid assessment plus seed funding for ARR). This high run rate is contributing to an erosion of the projected waiver cushion.

Approved in FY2012 rates were the core update to cover inflation less productivity (1.56%), funding for the Medicaid assessment (1.9%), and seed funding for the Admission-Readmission Revenue (ARR) and Total Patient Revenue (TPR) programs (0.5%). The largest single contributor has been the policy for one-day stay cases. Under the one-day stay policy, these short stays are excluded from the Charge per Case (CPC) methodology. As a consequence, the remaining cases are now more expensive on average. The phenomenon continues to work in the system as one-day cases continue to convert to observation status. Compared to the first six months of FY2011, the effect of one-day stay conversions to observation status is contributing to an approximate 2% increase in the charge per case growth reported in Monitoring Maryland Performance. Further, two-day stays are also declining, with some of these cases apparently converting to observation status as well. The combined impact of the changes related to one-day and two-day stays is approximately 3% for the first half of the fiscal year over the first half of FY2011.

Finally, an analysis of this year's rates shows an increase in inpatient revenue as a result of rate realignment during the year's rate-setting process. As outpatient revenue has increased, rate realignment spreads these costs according to current allocations. The impact of the revenue shift was a 1.6% increase in inpatient revenue. Table 1 summarizes the impact of the contributing factors.

Table 1: Factors Contributing to FY2012 Charge per Case Growth

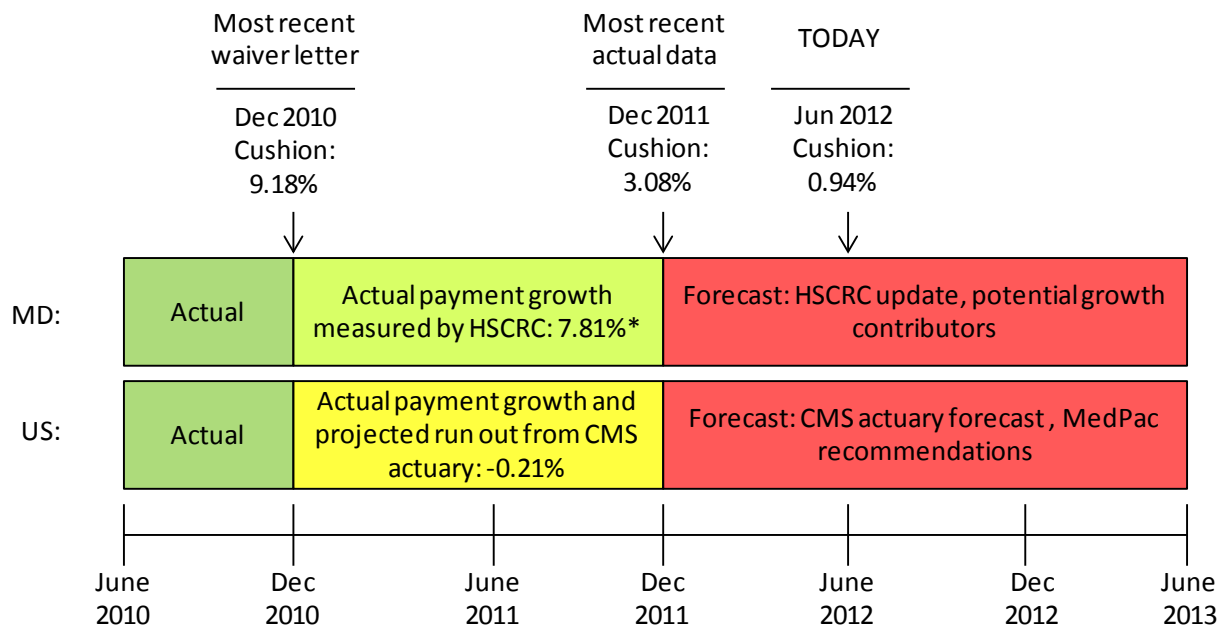
Factor	Impact (percentage points)
Core Update Factor	1.56
Medicaid Assessment	1.90
Rate Realignment	1.60
Seed Funding (ARR, TPR)	0.50
Short Stay Cases	3.00
Other	0.41
Total	**8.91**

Further contributing to erosion in our forecasted waiver cushion is the CMS actuary's revised forecast. The revised forecast projects lower case mix growth nationally in the near term, resulting in a drop in our forecasted waiver cushion.

At the March 2012 Commission meeting, the Commission adopted emergency measures to open some waiver room by accelerating the realignment of some inpatient room and board charges to the outpatient setting in anticipation of updated cost reports that would reflect the shift of cases to outpatient observation. The staff estimated that this action would open up 3% of waiver room in total, although only half will take place in FY2012 with an effective date of January 1, 2012 – midway through the fiscal year. This action would prevent failing the waiver in FY2012, but the margin would remain dangerously low. Further, the original forecast was too optimistic because of a continuing increase in the charge per case due to the policies around short stays, readmissions, and global budgets.

Figure 1 below shows the staff's most recent waiver model results. The most recent letter waiver letter puts the relative waiver test at 9.18%, as noted above. Based on trends from actual HSCRC data and the CMS Actuary's forecast for national Medicare spending, we estimate that the relative waiver test stood at 3.08% as of December 2011. Based on the emergency action taken by the Commission at the March 2012 meeting, we believe the relative waiver test for FY2012 (June 2012) will be 0.94%. This status sets a challenge before the system in establishing rates for FY2013.

Figure 1: Updated Wavier Forecast



* Measured actual Medicare growth. HSCRC measured all payer growth for the same period at 8.91%.

3. Financial Condition of Hospitals

In deciding how to proceed in this challenging environment, preserving the waiver is the primary goal. The methods used in saving the waiver, however, must take into account the financial condition for the hospitals providing care as well as the affordability of care to the patients in Maryland hospitals.

Table 2: Profits and Losses – Disclosure Report

Period	Net Operating Margins (regulated)	Operating Margins (unregulated)	Total Operating Margins	Net Profits
FY2010	6.45%	-38.25%	2.46%	3.67%
FY2011	7.49%	-38.07%	3.36%	6.44%

Table 2 shows both operating and total margins between FY2010 and FY2011. Despite continued losses on unregulated activities, operating margins rose from 2.46% to 3.36%. These data are found in the Disclosure Report, reflecting audited data reported annually to the HSCRC. These data are not available during the course of the year to monitor performance on a timely basis. However, the Commission requires hospitals to report monthly data to provide some insight into financial performance during the course of the year. These data are reported on FS schedules monthly to the Commission.

Table 3 summarizes financial performance for the first seven months of FY2012 compared to similar reporting for the first seven months of FY2011. The average regulated net operating margin has declined to 4.39% from 4.95% in FY2011, and average total net operating margin declined to 2.09% from 2.89% the previous year. While the data are not as accurate as the audited annual data, they show a trend toward lower profitability from operations. While limited update factors in previous years contribute to this decline, our analysis suggests that growth in expenses has outstripped revenue by nearly a percentage point.

Table 3: Profits and Losses, FS Schedules for 7 Months Ending January

Period	Net Operating Margins (regulated)	Operating Margins (unregulated)	Total Operating Margins	Net Profits
YTD Jan 2011	4.95%	-20.76%	2.89%	6.48%
YTD Jan 2012	4.39%	-23.90%	2.09%	6.39%

4. Short Stay Cases

The removal of short stay cases from the CPC methodology, while hospitals have increased utilization of observation services, has contributed to an increase in the average charge per case in Maryland, eroding our waiver status substantially. Under this policy, cases with 0 and 1 day length of stay were excluded from the CPC methodology. However, rate capacity for these cases remained in rates as the short stay cases were excluded from the CPC and valued at charges, raising the average CPC for the remaining cases included in the CPC for the remaining cases. This process has been happening gradually throughout FY2011 and FY2012, and the data suggest that the process will continue in FY2013. For the first seven months of FY2012, the effect of the shifts to observation is contributing approximately 3 percentage points of the observed 8.91% growth for all payers in the first seven months of the fiscal year. If this effect continues, the update factor for FY2013 must offset that impact to maintain compliance with the State's waiver.

An alternative/additional approach is to re-evaluate the short stay policy and modify the current methodology to reintegrate the short stay cases into the CPC targets. While this approach would not stop the conversion of short stay cases to observation status (nor should it when medically appropriate), this approach would reduce the rate of further erosion by reconnecting rate capacity to the remaining short stay cases.

However, reintegration of these cases is not as simple as reversing the policy because of the interaction with the readmissions policy, which excludes short stay cases. While the Admission Readmission Revenue (ARR) agreements would allow the cases to be reintegrated into the targets, this approach raises the possibility of unwarranted ARR rewards for further reductions in short stay cases. To avoid unintended consequences of this sort, reintegration of short stay cases into the target is not an appealing solution.

The remaining options are to address the short stay effect through a reduced update factor or to review which hospitals benefited most from the captured rated capacity left in rates as the short stay cases were removed and then adjust those hospitals specifically. The Commission, in determining that the rate capacity for the short stay cases should remain in rates, decided to use the update factor and scaling as the major tools to adjust for those distributional consequences.

5. Admission Readmission Revenue (ARR) Policy

The impact appears to be small at present as hospitals are just beginning to ramp up these efforts, but the future impact of reduced readmissions will erode the waiver margin further. Policy options include suspending the policy and further seed funding. However, distribution of the seed funding has begun, and hospitals are gearing up for the policy efforts. Further, to be exempt from Medicare's national policy, we must show that we meet or exceed the Medicare program's performance.

In anticipation of federal requirements for Medicare's treatment for readmissions, CMS asked the HSCRC to provide an explanation of current efforts around readmissions in Maryland. The staff provided a letter to CMS on January 31, 2012, describing both the ARR and TPR programs, explaining their goals, basic structures, and the incentives for reducing hospital readmissions within the State.

The effect of this policy, like that of the short stay policy, is to remove readmission cases, resulting in a higher average charge per case. Further, to provide incentives to hospitals to reduce readmissions, hospitals keep the revenue associated with readmissions that are avoided under the ARR policy. Because the revenue remains the same and is distributed across fewer cases, the charge per case will rise.

As noted in previous discussions of the readmission policy, hospitals have the opportunity to generate cost reductions and keep the revenue. There is no mechanism for sharing these savings with payers explicitly built into the policy. The method for sharing savings was to be a reduced update factor to hospitals in exchange for the ability to enhance profitability through improved productivity under the ARR policy. In discussions with CMS, described above, the expectation for savings is a minimum of 0.3% of inpatient revenue and a 5% reduction in readmissions. We estimate that the 5 reduction in Medicare readmissions in the ARR hospitals would result in a 0.58% increase in the charge per case for Medicare patients.

6. Total Patient Revenue (TPR)

FY2013 is the third and final year of the current Total Patient Revenue agreements. The phenomenon of moving low intensity cases from the hospital to more appropriate settings is similar to the phenomenon experienced with short stay cases and with reduced readmissions. Because low acuity, low charge cases are likely to be moved to other settings, remaining cases are likely to be more expensive, increasing the charge per case and resulting in further waiver deterioration. We estimate the impact for FY2012 to be 0.22% for Medicare charge per case.

Assuming this trend continues for another year, we would need to offset this rise in the update factor.

7. Medicaid Assessments

The FY2013 Medicaid budget assumes that the Medicaid deficit assessment will increase by $24 million, from $389 million to $413 million in FY2013. The total Medicaid deficit assessment now represents about 2.6 percentage points on the Medicare waiver test. In addition to this assessment, the FY 13 Medicaid Budget assumes that Medicaid cost containment measures relating to hospitals will save an additional $75 million in Medicaid costs, as follows:

- Tiering Outpatient Clinic and Emergency Services - $30 million General Funds (GF), $60 million total funds
- Pooling Disproportionate Share - $9.1 million GF, $18.2 million total
- Reducing Payment for Medically Needy Population - $36 million GF, $72 million total

In all, the Medicaid budget assumes additional savings from hospital-related policies of $99 million ($24 million in additional Medicaid Deficit Assessment + $75 million in cost containment/shifting measures).

The Medicaid budget also assumes that the HSCRC annual update factor will be 3.8% on inpatient services, and 4.65% on outpatient services, for a combined increase of 4.13%. This was identical to the update factor impact from FY2011 to FY2012. Under these assumptions, if the Commission adopts an update factor that is less than 4.13% Medicaid would achieve savings. These savings could be applied to the $99 million savings/additional assessment required in the budget. For each 1% below 4.13%, Medicaid is expected to achieve State savings of approximately $14 million.

The Department of Legislative Services (DLS) has suggested a budget amendment that would remove $14 million from these potential savings/additional assessment. DLS's recommendation, in essence, reduces the assumed update factor from 4.13% to 3.13%. Thus, if the Commission adopted an update factor of 3.13%, under this analysis, it could not apply the relating $14 million to reduce the other cost containment provisions. Given the stresses on the waiver test, the Commission will be compelled to undertake cost containment measures that have a direct impact on the waiver projections. Therefore, the $14 million budget cut would prevent the Commission from using this amount to make a small improvement in the waiver test.

The Senate accepted the $14 million cut, while the House rejected the cut. A conference committee will make final decisions on this cut after the final status is determined on other legislation regarding State revenue enhancements, and cost saving measures.

8. Waiver Modernization

The conflict between the Commission's efforts to meet the objectives of health care reform and the antiquated waiver test highlights the need for waiver modernization. The Secretary of Health and Mental Hygiene, the HSCRC Chairman, and Commission staff have discussed these issues with representatives from CMS. Those representatives had indicated that the best vehicle for waiver modernization is the State's Initiative to be announced as a CMMI grant. This initiative has not been announced by CMMI but is anticipated as early as April 2012.

These applications and grants will focus on proposals designed to reform the delivery system. In Maryland's application, the HSCRC staff, working with the Maryland Hospital Association and payer representatives from CareFirst and United Healthcare, is developing a proposal for an alternative waiver test for Maryland's all payer system. This work is proceeding in anticipation of the specific requirements of the federal initiative, and will need to be modified for the precise requirements of the initiative. However, the group has made significant progress on the elements of a modernized waiver test, how it should be measured, and the tools available to the rate-setting system to meet the requirements of a modernized waiver test and the goals of the triple aim of health care reform.

9. Improved monitoring and control of the system

A deficiency of the regulatory system at this point in time is the inability to monitor and identify the source of differences in approved and actual revenue growth. While *Monitoring Maryland Performance* shows inpatient charge per case growth in excess of approved rates during the course of the current fiscal year, it was February 2012 before the staff was able to determine the relative magnitudes of the contributing factors. Because of multiple complex methodology changes and data that are not available until well into the rate year, rate orders with unit rates and targets for compliance were difficult to complete. The effect is twofold – hospitals question their ability to comply with rates for a substantial portion of the year, and monitoring the status of the system is nearly impossible because no firm standard against which to measure actual charges is in place.

To remedy this situation, the staff will recommend revised procedures for FY2013 for establishing unit rates, Charge per Episode targets, and APR-DRG case weights. For FY2013, the staff proposes to use calendar year 2011 data to prepare rate orders for the industry.

OPTIONS FOR FY2013 RATES

Based on the preceding discussion, the staff proposes the following items for the Commission to consider regarding the update factor for FY2013:

Action 1: Options for inpatient rates

The staff believes that an inpatient update of -1% is necessary to generate even a minimal waiver cushion. An adjustment of -1% will produce some waiver cushion and allow the system time to negotiate a modernized waiver under the CMMI States' Initiative. For FY2013, we estimate that the relative waiver test would be 1.38% if inpatient rates are updated by -1%.

In the staff's modeling of our current waiver status, we estimate that an update factor of 0.54% to inpatient rates will leave the relative waiver test at 0% -- a breakeven calculation. These scenarios assume that current trends continue: short stay cases drive rates at 3 percentage points above what is approved in rates; the readmissions policy generates a charge per case increase of 0.58 percentage points for a 5% reduction in readmissions; TPR trends continue to increase the charge per case, adding an additional 0.22 percentage points to the charge per case growth; and previously approved capital costs are put into rates, adding 0.18 percentage points.

The 3 percentage point growth associated with the short stay cases appears to be large given the movement witnessed to date. However, Maryland hospitals started at a rate of 22.5% readmissions and through the first half of this fiscal year were around 18.5%. The national average sits at about 14%. Given the distance we have to go and the fact that hospitals have moved differentially on this front, further erosion is likely to continue. This is consistent with yet another month of increase in the reported charge per case in *Monitoring Maryland Performance* for year-ending January 2012, rising to 8.91% from the 8.8% for year-ending December 2011.

To better understand the sensitivity to alternative choices, Table 4 below shows the inpatient update factor and the relative waiver test for FY2013 under that update. These values are designed to show either the cushion associated with specific proposals or to demonstrate the sensitivity around those values.

Table 4: Relationship between the Inpatient CPC Update and Relative Waiver Cushion for FY2013

Inpatient CPC Update	Relative Waiver Cushion
2.47%	-1.85%
1.46%	-0.81%
1.00%	-0.40%
0.55%	0.00%
0.00%	0.45%
-1.00%	1.39%
-1.50%	1.85%

This recommendation does not include any allowance for case mix. Some industry representatives have suggested that a small case mix budget be allowed to cover costs associated with changing patient acuity and to provide for incentives to continue proper coding and documentation. Because of the need for tight limitations on inpatient revenue, this allowance would need to be small and would need to be a part of the overall update to inpatient revenue. For example, an alternative to a -1% inpatient CPC update would be to implement an inpatient update factor of -1.25% on the CPC/CPE targets and allow the industry 0.25 percentage points for case mix for a net -1.0 percent decrease.

Action 2: Options for outpatient rates

The options for outpatient rates are not hinged upon waiver status. The Medicare waiver is an inpatient test only. Hence, outpatient rates are not subject to the same constraint. However, as part of the emergency measures adopted by the Commission last month, substantial revenue was shifted back to outpatient rates, recognizing the lag in the alignment of costs from dated cost reports and the current shift toward outpatient services. This shift of revenue increased outpatient rates by approximately 5%, raising the issue of affordability if outpatient charges are allowed to rise while inpatient rates are constrained by the Medicare waiver test.

Traditionally, the update factor has been uniform between inpatient and outpatient services. Under this scenario, a reduction to inpatient rates would apply to outpatient as well. However, in the past, the Commission has provided differential update factors for inpatient and outpatient services. Industry representatives have suggested that outpatient services should be updated by factor cost inflation. The full market basket would provide an overall revenue increase of about 0.3%.

Other options would include a 0% update on outpatient or something between 0% and full inflation, reflecting concerns for affordability for outpatient services but providing less of a financial hit that the full reduction in inpatient rates.

The staff invites comments around a reasonable update for outpatient services.

There is a technical issue to note regarding the implementation of a differential update factor for inpatient and outpatient services. Because a number of ancillary rate centers have both inpatient and outpatient services but only a single unit rate, these centers would produce a rate change that is a weighted average of the inpatient and outpatient shares. However, the charge per case for inpatient services would not then be as low as the targeted rate. If the Commission approved a -1% update factor for the inpatient services and a different update factor for the outpatient services, pure inpatient centers would need to be lowered by more than 1% to achieve a full 1% reduction in the average inpatient charge per case.

Action 3: Do not allocate additional ARR seed funds in FY2013

As the system attempts to open up additional room under the Medicare waiver test, the time is right to reconsider revenue to be placed into rates in FY2013 for the ARR program. The first year of funding has already been placed into rates, but the second year has not yet been allocated. Given the pressures the system faces under the Medicare waiver, even the small amount associated with the ARR policy implementation represents waiver room that should be preserved. Further, given the need to generate savings under the readmission policy, this loan to hospitals on top of the incentives provided by allowing the hospitals to retain savings in the first years of the readmissions program should be a relatively low priority for funding. By not granting these monies in rates, the system would save 0.3% under the relative waiver test.

Action 4: Streamline system controls

Base the production of FY2013 unit rates, CPE targets, and case mix weights using Calendar Year 2011. This introduces a 6 month lag between the annual data and the tools needed to monitor the system. This lag will allow the staff the opportunity to complete rate orders near the beginning of the fiscal year. This approach is necessary to monitor and control the prospective rate-setting system, and to provide hospitals the opportunity for appropriate compliance. The FY2012 case mix weights were developed based on the Calendar Year 2010. Determining unit rates and CPE targets using calendar year will also align the time intervals in methodologies. Given the projected status of the waiver and the narrow margin that will remain under the current assumptions, the Commission and the staff require better controls to monitor the system's status and to quickly respond to changes and would enable the action 6 listed below.

Action 5: Establish policy for Medicaid assessments

To meet the legislative requirements regarding assessments and savings for the Medicaid program, the Commission will authorize tiering of outpatient rates for the emergency room and clinics. Hospitals must submit plans for tiering for approval by HSCRC staff. The staff will contact the hospitals that are the top candidates for generating savings under this approach and execute a memorandum of understanding.

The precise actions to be taken depend on the inpatient and outpatient updates adopted. To the degree that savings are available, the day limits associated with the Medically Needy program should first be addressed. The next priority would be the $24 million in increased assessments, which if put into rates, would cause further deterioration in the waiver. The $9 million associated with the DSH proposal would be the last piece to be addressed, if necessary.

Action 6: Revisit the update factor in January 2013

This action is necessary for two reasons. All parties have noted the considerable uncertainty around many of the items incorporated into this forecast: the continued effect of short stays, the

size of the ARR and TPR effects, the Medicare update and a potential Coding and Documentation adjustment, etc. Revisiting the update in January 2013 would allow the Commission to consider whether the approved update is too severe, or alternatively, whether the adjustment is sufficient to maintain compliance with the waiver based on the best forecast available. The Commission will need to approve an update factor policy for FY2013 before the Medicare Inpatient Prospective Payment System final rule will be adopted and probably before the final status of the federal sequester, which is in current law, is determined.

Action 7: Updates for non-waiver hospitals

The HSCRC sets rates for certain hospitals that are not under the Medicare waiver (private psychiatric hospitals for example). The staff invites comments to specifically address this issue, which has not been discussed to date at the update factor meetings.

Action 8: Continuation of the inpatient reallocation for FY2013

The staff recommends that the Commission continue the inpatient reallocation to outpatient centers approved by the Commission for FY2012 into FY2013 as well. The first cost reports to generally reflect the cost reallocations associated with the substantial shift to observation will be FY2012 reports affecting rates for FY2014. The staff recommends the reallocation continue in FY2013 as the system awaits these more accurate cost reports for rate realignment.

Action 9: Scaling

Because of the suspension of the CPV and the substantial shifts occurring under the various bundling methodologies, the Reasonableness of Charges (ROC) methodology needs to be revisited. However, a Medicare screen should be reconstituted but should not be used for the basis of scaling in FY2013. Such a screen can be used as a tool for monitoring performance, and identifying emerging issues.

Further, substantial revenue for scaling is already associated with MHAC and QBR policies. The staff recommends that there be no ROC scaling in FY2013 as the methodology is redesigned. Further, the staff recommends that no lower floor be placed on total quality scaling to prevent the full impact of quality scaling on hospitals.

Action 10: Volume adjustment

While the staff has been reviewing arguments for the appropriate calculation of volume based on equivalent admissions, we do not believe this is the appropriate time to implement a more aggressive volume adjustment. Because we are still operating under the legislatively established waiver methodology, a decrease in volume would increase the inpatient charge per case by putting revenue back into the system, further exacerbating our deterioration. While payer

representatives have made convincing arguments about how to modify the traditional calculation to properly capture volume, this argument has not been publically debated and vetted. Nor does it protect the system in the event of a volume downturn.

We believe a more aggressive volume adjustment is a valuable tool for a modernized waiver test that focuses on spending per beneficiary, and this option will receive full consideration in that context. We believe it is premature, however, under the current waiver test.

Action 11: Differential

At the March 2012 Commission meeting, hospital representatives argued that the Medicare differential should be increased. The staff does not believe that there is sufficient foundation to consider such a proposal based on current information. Hospital representatives have pledged to evaluate the cost-based justification for the current 6% differential and present those findings to the staff.

Draft Recommendations on Continued Financial Support for the Maryland Patient Safety Center

April 4, 2012

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

This is a Draft Recommendation to be considered at the April 11, 2012 HSCRC public meeting. Any Comments must be e-mailed to Dianne Feeney at dfeeney@hscrc.state.md.us by COB on April 23, 2012.

Draft Recommendations on Request for HSCRC Financial Support of Maryland Patient Safety Center in FY 2013

Background

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

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

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

In 2004, the HSCRC adopted recommendations that made it a partner in the initiation of the MPSC by providing seed funding through hospital rates. The recommendations provided funding to cover 50% of the reasonable budgeted costs of the Center. The Commission annually receives a briefing and documentation 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 evaluated the reasonableness of the budget items presented and made recommendations to the Commission.

Over the past 8 years, the rates of eight Maryland hospitals were increased by the following amounts, and funds have been transferred on a biannual basis (by October 31 and March 31 of each year):

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

- FY 2011 - $1,544,594
- FY 2012 - $1,314,433

For FY 11, the Commission held in abeyance $171,622 of the total approved funding ($1,544,594) until the MPSC demonstrated that a viable fundraising plan was in place. A plan was submitted to the Commission in March 2011, however, the economic down-turn hindered the Center's ability to achieve the fundraising goals outlined in the 2011 and 2012 plans. In addition, the MPSC consolidated programs and improved efficiency, resulting in a reduction in the overall expenses of the Center for FY 12, and for what is proposed for FY 13.

Maryland Patient Safety Center Request to Extend HSCRC Funding

On March 27, 2012, the HSCRC received the attached request for continued financial support of the MPSC through rates in FY 2013 (Appendix 1). The MPSC is requesting to continue the 45% HSCRC match into FY 2013. The result would be a reduction in total support from $1,314,433 in FY 12 to $1,225,637 in FY 13-- a 6.8% decrease.

Strategic Partnerships

The MPSC, through the years, has established and continued to build upon strategic partnerships with key organizations to achieve its mission and goals. These organizations and their joint activities with the MPSC are described below.

- Delmarva Foundation for Medical Care – The regional Quality Improvement Organization serving Maryland. The Delmarva Foundation is a subcontractor to the Maryland Patient Safety Center and facilitates the Maryland Hospital Hand Hygiene Collaborative, the SAFE from FALLS Collaborative, and the Perinatal and Neonatal Collaborative, among other efforts
- Maryland Healthcare Education Institute – The educational affiliate of the Maryland Hospital Association. The Maryland Healthcare Education Institute is a subcontractor to the Maryland Patient Safety Center and provides a variety of patient safety education and training programs to the Center's members, as well as coordinating large meeting events
- Institute for Safe Medication Practices – The leading national organization educating others about safe medication practices. The Institute for Safe Medication Practices is a subcontractor to the Maryland Patient Safety Center for its MedSAFE program
- ECRI Institute – A national vendor of adverse event reporting services. ECRI is a subcontractor to the Maryland Patient Safety Center providing a secure adverse event reporting system and analytic capability
- The Armstrong Institute for Patient Safety and Quality – The new patient safety center within Johns Hopkins Medicine. The Armstrong Institute is a subcontractor to the Maryland Patient Safety Center leading the reduction of central line-associated blood stream infections in outpatient dialysis centers

Maryland Patient Safety Center Purpose, Activities, Accomplishments, and Outcomes

The purpose of the MPSC is to make Maryland's healthcare the safest state in the nation focusing on the improvement of systems of care, reduction of the occurrences of adverse events, and improvement in the culture of patient safety at Maryland health care facilities. The MPSC's new strategic plan directs concentration on the following areas:

- Preventing harm and demonstrating the value of safety through-
  - MEDSAFE Survey and Conference
  - SAFE from FALLS
  - Maryland Hospital Hand Hygiene Collaborative
  - Perinatal and Neonatal Learning Collaborative
  - Central Line-Associated Blood Stream Infections
- Spreading excellence through-
  - MPSC Annual Conference
  - TeamSTEPPS™
  - Education Courses
  - Adverse Event Reporting System
- Leading innovation in new areas of safety improvement.

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

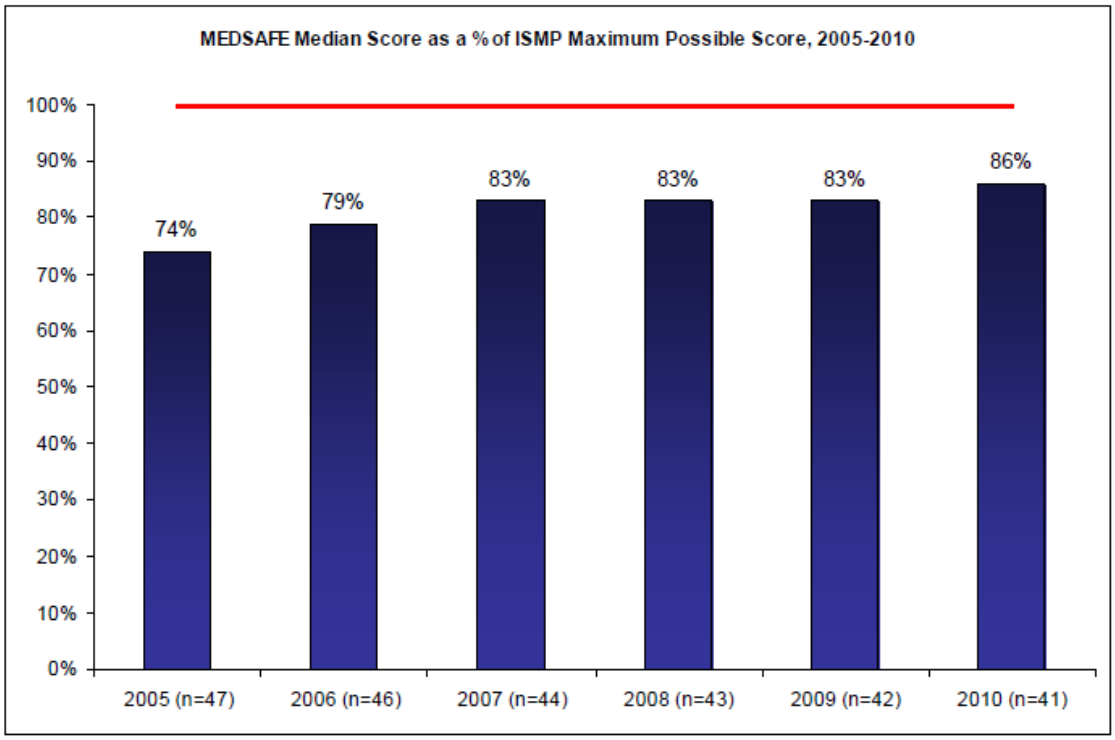
MEDSAFE

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

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

Table 1 below illustrates hospitals' improvement in scores on the ISMP self-assessment survey. The tool was significantly modified after 2010, therefore, the MPSC will monitor and report to the Commission trends in the scores beginning next year after a full base and performance year of scores using the new tool have been collected.

Table 1. MEDSAFE Score Trends from 2005 to 2010



SAFE from FALLS

The purpose of the SAFE from FALLS program is to reduce the incidence and severity of patient and resident falls in hospital, nursing home, and home health settings in Maryland. Launched in 2008, the SAFE from FALLS program has 30 hospitals, 20 long term care facilities, and 6 home health care providers participating. Each organization collects data on falls, education, and best practices for preventing falls. This is an important area for the MPSC to focus as:

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

Table 2 below illustrates the management program and care bundle components of the program.

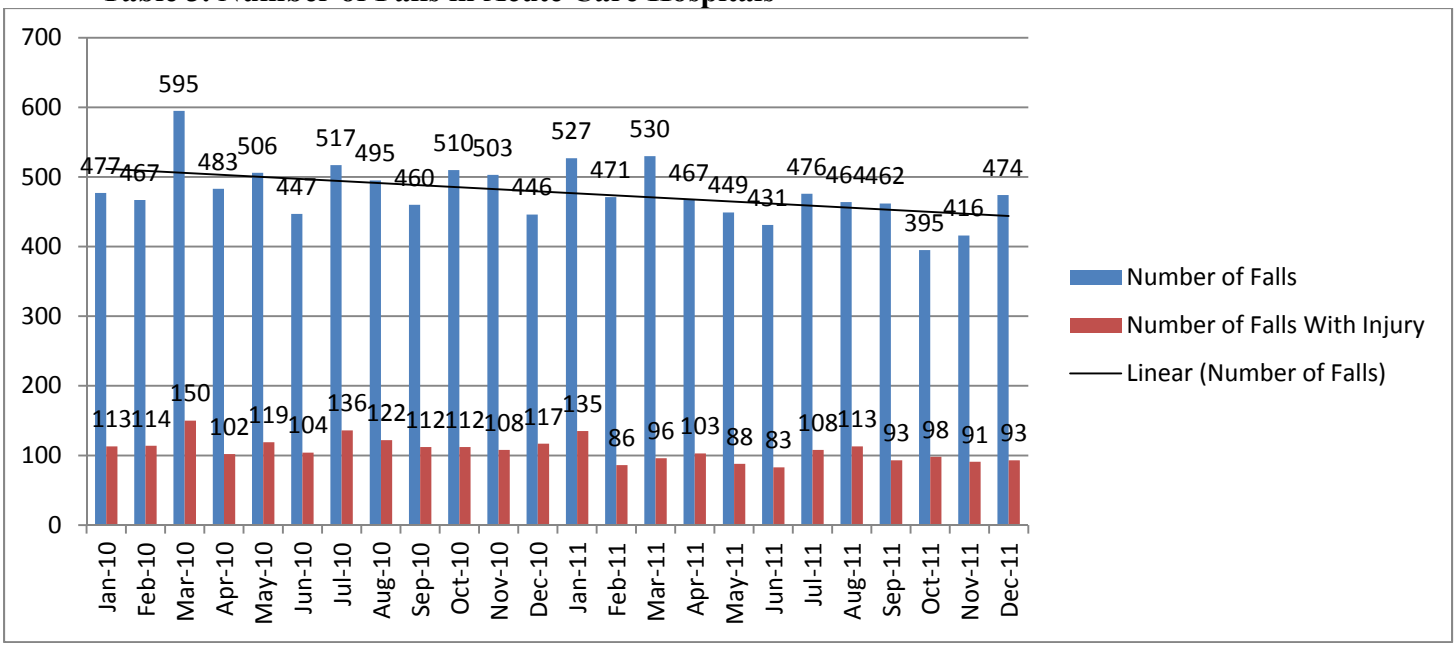
Table 2. SAFE from FALLS Management Program and Care Bundle

Participants engage in a falls management program and a patient/resident care bundle:

Fall Management Program	Patient/Resident Care Bundle
S – Safety coordination	**F** – Falls risk screening
A – Accurate and concurrent reporting	**A** – Assessment of risk factors
F – Facility expectations, staff education	**L** – Linked interventions
E – Education for patients and families	**L** – Learn from events
	S – Safe environment

As illustrated in Table 3, the trend line reveals a modest decline in the number of falls in the acute care hospital care from January 2010 to the present.

Table 3. Number of Falls in Acute Care Hospitals



The MPSC estimates that, in total, 965 falls have been prevented through the Collaborative with an estimated $6,532,085 in cost savings.

Perinatal and Neonatal Learning Collaborative

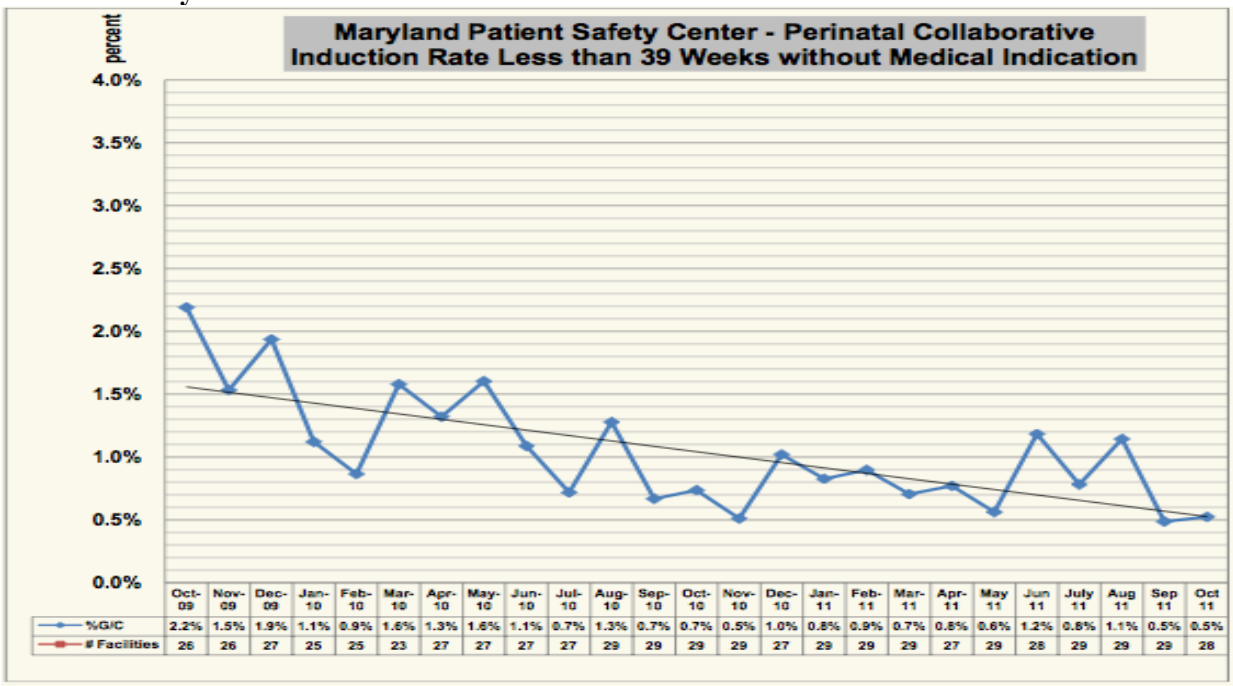
The purpose of the perinatal and Neonatal Learning Collaborative is to reduce elective inductions and c-sections prior to 39 weeks without medical indication, improve neonatal outcomes, and standardize the discharge process for mothers and infants including the late pre-term infant. Table 4 below outlines the implementation and ongoing work timeline of what is now the Perinatal and Neonatal Learning Collaborative.

Table 4. Perinatal and Neonatal Learning Collaborative Timeline

Collaborative	Focus
Perinatal Collaborative	• Launched in 2007 • Initial funding by Dept of Health and Mental Hygiene • 30 of 34 Maryland birthing hospitals, touching 90% of births in the state • Aim: reduce infant harm through integration of systems improvements and team behaviors into maternal-fetal care; Create perinatal units that deliver care safely and reliably with zero preventable adverse events
Neonatal Collaborative	• Launched in 2009 • Initial funding by CareFirst BlueCross BlueShield • 26 birthing hospitals from MD, DC and VA • Aim: improve neonatal outcomes by reducing neonatal morbidity, mortality and cost of care. Includes using standardized resuscitation and stabilization of the neonate in the first hour of life, the "golden hour", and improving teamwork and communication through use of team behaviors, including the family, in neonatal care
Perinatal/Neonatal Learning Network	• Merged in 2012 • 32 of 34 Maryland birthing hospitals • Aim: Standardize the discharge process for mothers and infants including the late pre-term infant

Tables 5 and 6 below illustrate the decrease in rates of early, elective deliveries as measured by collaborative hospital participants. These measures are targeted at decreasing neonatal mortality, and morbidity.

Table 5. Early Elective Induction Rates October 2009-October 2011



Tabe 6. Early Elective Cesarean Section Rates October 2009 to October 2011

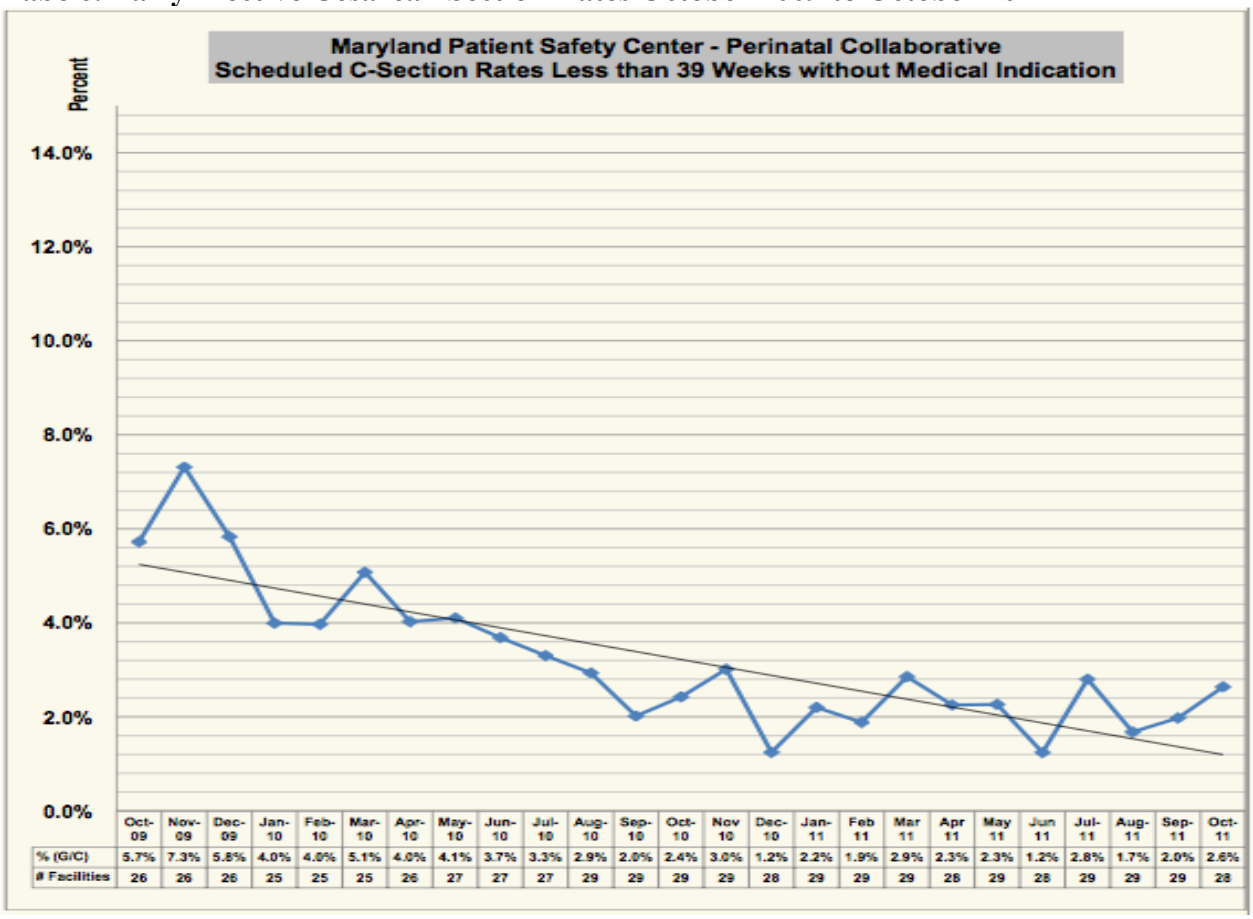


Table 7 below illustrates the improvements in the neonatal measure results achieved thus far as well as the goals set for each measure.

Table 7. Neonatal Measures October 2009 to November 2011

Golden Hour Measures				
	Baseline 7/1/09 -9/30/09	10/1/09 - 9/30/10 (Rolling 12 mos)	10/1/10 - 11/30/11 (Rolling 12 months)	Goal
Pulse Oximetry (Reported Monthly)	24%	38% (58% improvement over baseline)	49% (104% improvement over baseline)	80%
1-Hour Surfactant (Reported Monthly)	81%	85% (5% improvement over baseline)	86% (6%improvement over baseline)	100%
Axillary Temperature (Reported Monthly)	36%	20% (44% improvement over baseline)	13% (64% improvement over baseline)	0%
Average Initial LOS (Reported Monthly)	20 days	15 days (25% reduction from baseline)	31 days (55% increase over baseline)	10% relative reduction from baseline
1-Hour Antibiotics (Reported Monthly)	36%	30% (17% decline from baseline)	56% (56% improvement over baseline)	100%
1-Hour Surfactant (Reported Monthly)	81%	85% (5% improvement over baseline)	86% (6% improvement over baseline)	100%
	Baseline 1/1/09 - 6/30/09	7/1/09 - 6/30/10 (Rolling 12 mos)	7/1/10 - 6/30/11	
Chronic Lung Disease (Reported Quarterly)	15%	11% (27% reduction from baseline)	7% (53% reduction from baseline)	10% relative reduction from baseline
Mortality Rate (Reported Quarterly; results are per 100 live births meeting gest. age criteria in study)	5 per 100	6 per 100*	5 per 100	10% relative reduction from baseline

* Change not statistically significant using Fisher's Exact Test. P = 0.707134

In addition to the above accomplishments, the collaborative demonstrates high scores for 2012 on the AHRQ Culture of Safety Survey for staff on OB units compared with the national average for all hospital OB staff respondents. Table 8 below illustrates Maryland scores compared to the nation.

Table 8. AHRQ Culture of Safety Survey Results MD Compared to the Nation

	2011 Combined Collaborative AHRQ Survey Average	AHRQ 2012 User Comparative Database Report – OB Unit	2009 Perinatal Collaborative AHRQ Survey Average	2009 Neonatal Collaborative AHRQ Survey Average
Overall Perceptions of Safety	75%	64%	62%	65%
Frequency of Reported Events	82%	63%	59%	54%
Supervisor/Manager Expectations & Actions Promoting Safety	84%	73%	73%	74%
Organizational Learning - Continuous Improvement	90%	72%	73%	75%
Teamwork within Units	90%	81%	82%	86%

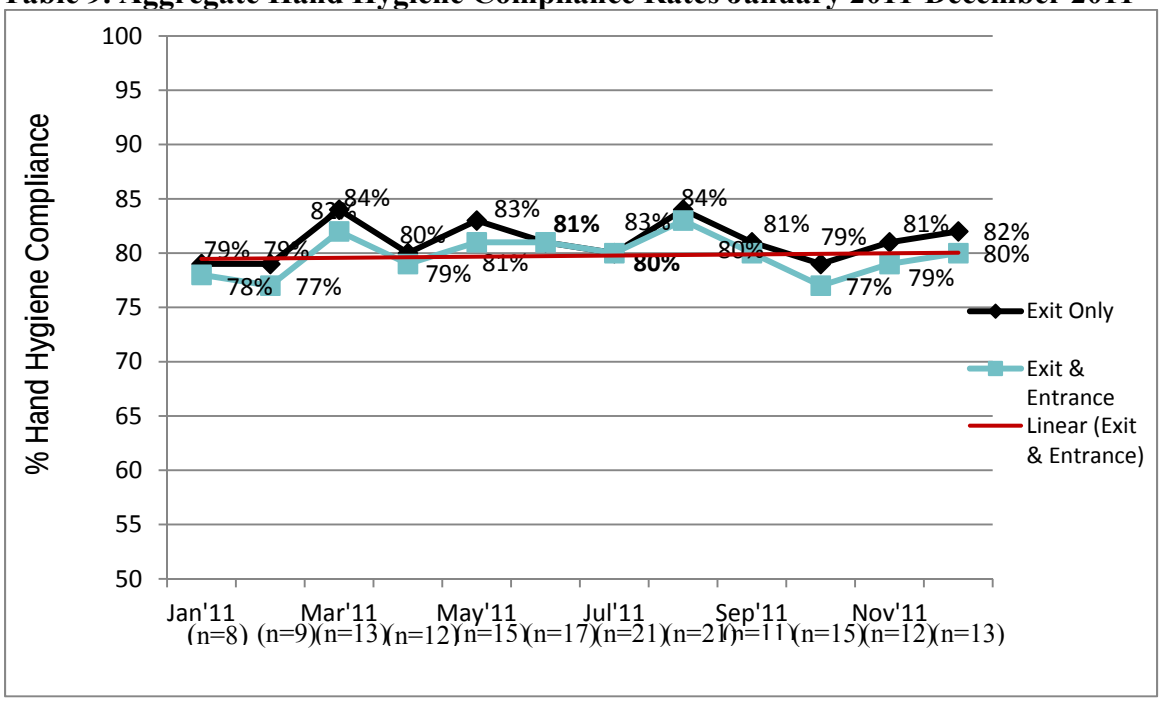
	2011 Combined Collaborative AHRQ Survey Average	AHRQ 2012 User Comparative Database Report – OB Unit	2009 Perinatal Collaborative AHRQ Survey Average	2009 Neonatal Collaborative AHRQ Survey Average
Communication Openness	79%	61%	60%	62%
Feedback and Communication About Error	82%	62%	58%	56%
Non-punitive Response to Error	53%	41%	39%	43%
Staffing	77%	61%	63%	67%
Hospital management support for patient safety	82%	69%	69%	69%
Teamwork Across Hospital Units	75%	58%	56%	55%
Hospital Handoffs & Transitions	71%	56%	52%	52%

Going forward, the MPSC has begun to analyze disparities in geographic areas for neonatal and perinatal outcomes and will focus on improving these disparities, and include disparities improvements in their report to the Commission.

Hand Hygiene Collaborative

The purpose of the Hand Hygiene Collaborative is to reduce preventable infections in Maryland through better hand hygiene. Key components of the program include use of unknown observers to record hand cleansing upon exit from or entry to patient rooms, and a requirement that 80% of the units of a participating hospital collect 30 observations each month. Participation includes 30 hospitals with 9 additional hospitals that have recently made commitments to participate. Led by the MPSC, the effort is supported and staffed by the Delmarva Foundation and MHA. As illustrated in Table 9, a relatively small number of participating hospitals have met the 80% of units and 30 observations criteria, and improvements have not been documented as of yet.

Table 9. Aggregate Hand Hygiene Compliance Rates January 2011-December 2011



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

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

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

Adverse Event Reporting

The MPSC has recently adopted the ECRI adverse event reporting system and offers it to all hospitals in the state for self-reporting of adverse events. Hospitals may select a Patient Safety Organization of their choosing with whom they submit confidential adverse event data. Seven hospitals currently submit their data to the MPSC

ECRI system but the Center anticipates a modest increase in participation in the coming year.

Spreading Excellence through Educational Programming

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

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

These programs, particularly the LEAN and Six Sigma programs are designed to improve efficiency and reduce costs at hospitals and nursing homes. One facility has reported savings of up to $20,000 related to pharmacy inventory reductions, and annualized savings of up to $2.2 million due to reduced cases of missing or reordered medications. Table 10 illustrates numbers of hospital staff participating in these programs for 2012 and to date.

Table 10. Participants and Hospitals Accessing MPSC Educational Programs

Education Programs	**FY12**			**Cumulative**	
	Participants	Hospitals	Avg Evaluation (4.0 scale)	Participants	Hospitals
TeamSTEPPS™	55	10	3.6	342	55
Root Cause Analysis	113	34	3.7	641	67
Failure Modes Effects Analysis	28	14	3.8	401	64
Accountability Matters	33	17	*	171	38
Lean Healthcare	41	18	3.61	412	52
Six Sigma Greenbelt	46	18	3.69	265	49
Annual Conference	1230	63	*	4848	81

Other Sources of Funding

In, FY 12, MPSC continued its efforts to work with its partners to secure program-specific funding, and estimates the amounts they will secure for FY 2013 as illustrated in Table 11.

Table 11. Other MPSC Funding FY 12and FY 13

Source	FY 2012	2013
Maryland Hospitals	$250,000	$300,000
Delmarva Foundation	$200,000	$200,000
Maryland Hospital Association	$200,000	$200,000
DHMH Restricted Grant	$250,00	$250,00
Education Session Revenue	$293,000	$373,000
CareFirst Grant Neonatal Collaborative	$75,000	
Long Term Care Facilities	N/A	$200,000
Additional Grant Applications	$388,419 (Applied to CareFirst to blend concepts within TeamSTEPPS and CUSP (Comprehensive Unit-based Safety Program)	TBD

Findings

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

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

Staff continues to believe that, although the programs of the MPSC seem to be well conceived, there tends to be a general lack of coordination with other patient-safety related initiatives across the state. Staff believes there that should be a broader plan for patient safety in Maryland, and that the MPSC should take a lead in that plan. In addition, the statewide patient safety plan should be considered in the context of overall delivery system reform. Over the past year, MPSC has made efforts to better coordinate with State and other entities, such as the Department of Health and Mental Hygiene, and the Maryland Health Quality and Cost Council, on State priorities. The roles of the various State entities involved with patient safety should be clearly defined. Moreover,

HSCRC staff believes that, with the expansion of the scope of MPSC programs to benefit patients in various provider settings, it is important to ensure that the Center is not directly associated with or dominated by any one type of provider.[1]

Commission recommendations before FY 2010 provided financial support to the MPSC equal to 50% of the reasonable budgeted expenses of the Center (less half of any carryover from the previous year). Beginning in FY 2010, the Commission's recommendations stated that this percentage should decline each year by at least 5%, but in no year should the dollar amount be greater than the previous year. The intent was to reduce support gradually and to encourage the MPSC to aggressively pursue other sources of revenue (including from other provider groups that benefit from Center programs) to help support the Center into the future.

In FY 10, the percentage support was reduced to 45%; however, recognizing the difficulty of raising funds during tough economic times, the Commission retained the 45% contribution in FYs 11 and 12. Nonetheless, the Commission's amount of support has declined on a dollar basis in each of the past 3 years and is proposed to decrease in FY 13:

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

Prior to this past year, the policy to limit the dollar amount of support so as not to exceed what was granted the previous year may not actually reduce the amount of support by the Commission, as intended. The intent was to have fundraising dollars offset funding support provided through the Commission. In addition, since it is the Commission's policy to reduce the support by half of the carryover, it has made it difficult for the Center to build up a reasonable budgetary reserve.

In light of the issues, presented above, staff recommends the following changes to the MPSC funding support policy.

Staff Recommendations:

1. **Provide funding support for the MPSC in FY 2013 through an increase in hospital rates in the amount of $1,225,637 (a 7% reduction from FY 2012).**

2. **Remove the requirement of reducing the support by half of the carryover to support the Center in building up a reasonable budgetary reserve.**

[1] HSCRC staff has met with MPSC on several occasions to consider: how the Center can assist with HSCRC payment initiatives, such as readmissions, and, options for relocating the MPSC separate from the MHA.

3. **Hold in abeyance $100,000 of the requested funding until the MPSC develops and submits to the Commission a feasibility study and options for relocating the MPSC to space outside of the existing Maryland Hospital Association complex. The study and proposed options should be submitted the Commission no later than December 31, 2012.**

4. **Similar to FY 12, staff recommends that as part of the FY 13 MPSC funding recommendation, staff consider the funding request on an annual basis. Funding support in the future should consider: (1) how well the MPSC initiatives fit into a broader statewide plan for patient safety; (2) whether new MPSC revenues should offset HSCRC funding support; (3) how much MPSC has in budgetary reserve; (4) information on patient safety outcomes and the public's return on investment (from HSCRC funding); and (5) how MPSC initiatives dovetail with the HSCRC's payment-related initiatives and priorities, and other relevant patient safety activities.**

5. **The MPSC should 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.**

Appendix I

Maryland Patient Safety Center 2012 Report and

2013 Proposed Plan and Budget

Maryland Patient Safety Center FY 2013 Program Plan & Budget

Presented to the Health Services Cost Review Commission

April 11, 2013

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 2009 through 2014
- In 2007, the Maryland Patient Safety Center was incorporated as a 501(c)(3) organization
- In 2008, listed as a federal Patient Safety Organization. Recently re-listed through 2014

MPSC Awards & Distinctions

- Recognized at the 2009 National Patient Safety Foundation Annual Conference and Institute for Healthcare Improvement Conference
- Honored in 2005 with the Agency for Healthcare Research and Quality's John M. Eisenberg Patient & Safety Quality Award
- Considered a model by other states. The Maryland Patient Safety Center has acted as host and resource for other states interested in creating something similar
- Selected by the Maryland Health Quality & Cost Council to lead the statewide Maryland Hospital Hand Hygiene Collaborative
- First state organization to submit harm prevention data to the Centers for Medicare and Medicaid Services as part of the Partnership for Patients initiative
- 93% (50 of 54 Maryland hospitals) have made annual voluntary contributions to the Center in 2012

Board of Directors Maryland Patient Safety Center

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

Strategic Priorities

MARYLAND Patient Safety CENTER

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 health care 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

Strategic Dashboard

Prevent Harm and Demonstrate the Value of Safety	•MEDSAFE Survey and Conference • SAFE from FALLS • Maryland Hospital Hand Hygiene Collaborative • Perinatal and Neonatal Learning Collaborative • Central Line-Associated Blood Stream Infections
Spread Excellence	• MPSC Annual Conference • TeamSTEPPS™ • Education Courses • Adverse Event Reporting System
Lead Innovation in New Areas of Safety Improvement	• Guide to Patient and Family Engagement in Hospital Safety and Quality

Strategic Partners

- **Delmarva Foundation for Medical Care** – The regional Quality Improvement Organization serving Maryland. The Delmarva Foundation is a subcontractor to the Maryland Patient Safety Center and facilitates the Maryland Hospital Hand Hygiene Collaborative, the SAFE from FALLS Collaborative and the Perinatal and Neonatal Collaborative, among other efforts

- **Maryland Healthcare Education Institute** – The educational affiliate of the Maryland Hospital Association. The Maryland Healthcare Education Institute is a subcontractor to the Maryland Patient Safety Center and provides a variety of patient safety education and training programs to the Center's members, as well as coordinating large meeting events

- **Institute for Safe Medication Practices** – The leading national organization educating others about safe medication practices. The Institute for Safe Medication Practices is a subcontractor to the Maryland Patient Safety Center for its MedSAFE program

- **ECRI Institute** – A national vendor of adverse event reporting services. ECRI is a subcontractor to the Maryland Patient Safety Center providing a secure adverse event reporting system and analytic capability

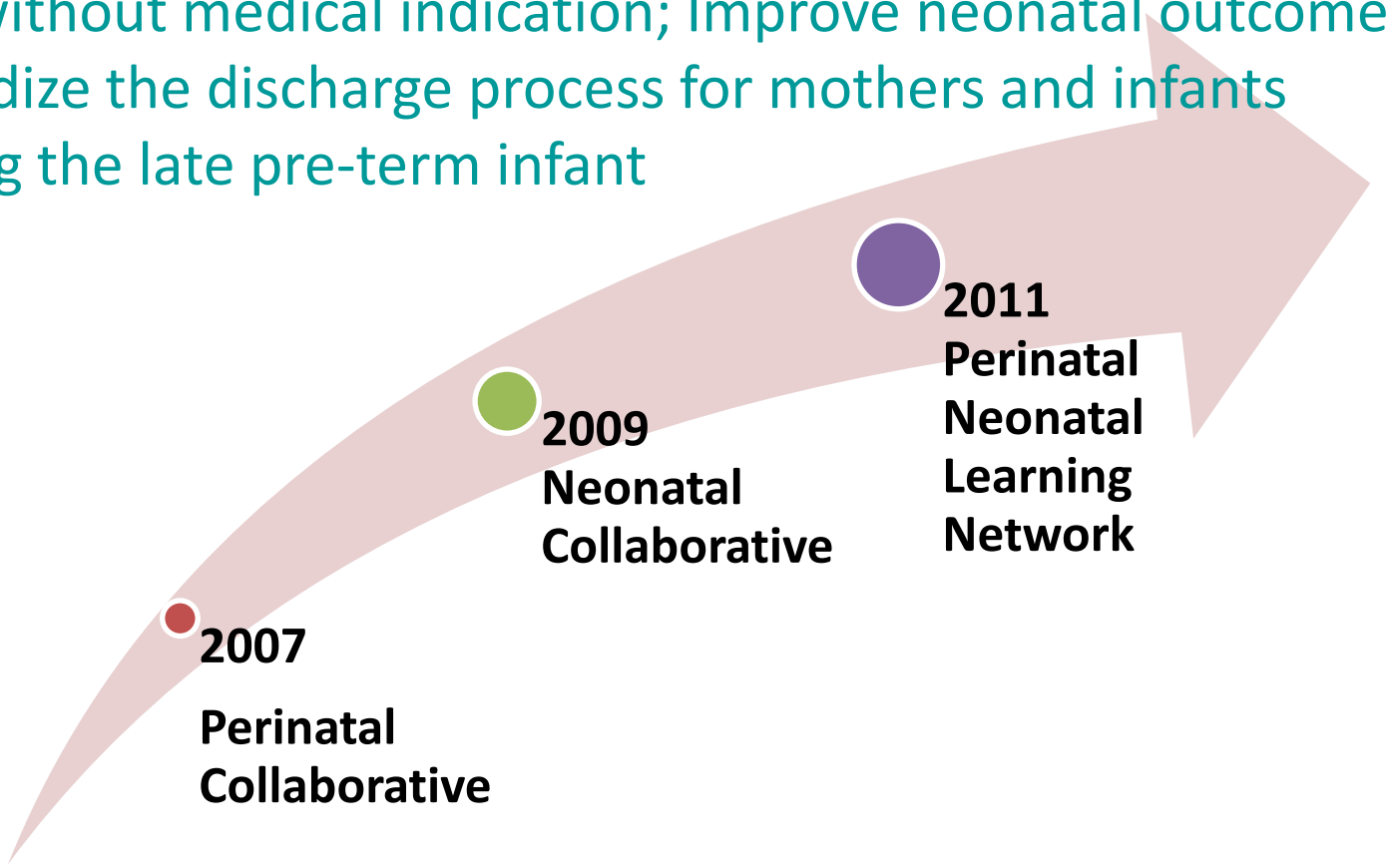
- **The Armstrong Institute for Patient Safety and Quality** – The new patient safety center within Johns Hopkins Medicine. The Armstrong Institute is a subcontractor to the Maryland Patient Safety Center leading the reduction of central line-associated blood stream infections in outpatient dialysis centers

Collaboratives: Purpose and Results

- Perinatal/Neonatal Collaborative
- SAFE from FALLS
- Maryland Hospital Hand Hygiene Collaborative

Perinatal/Neonatal Collaborative

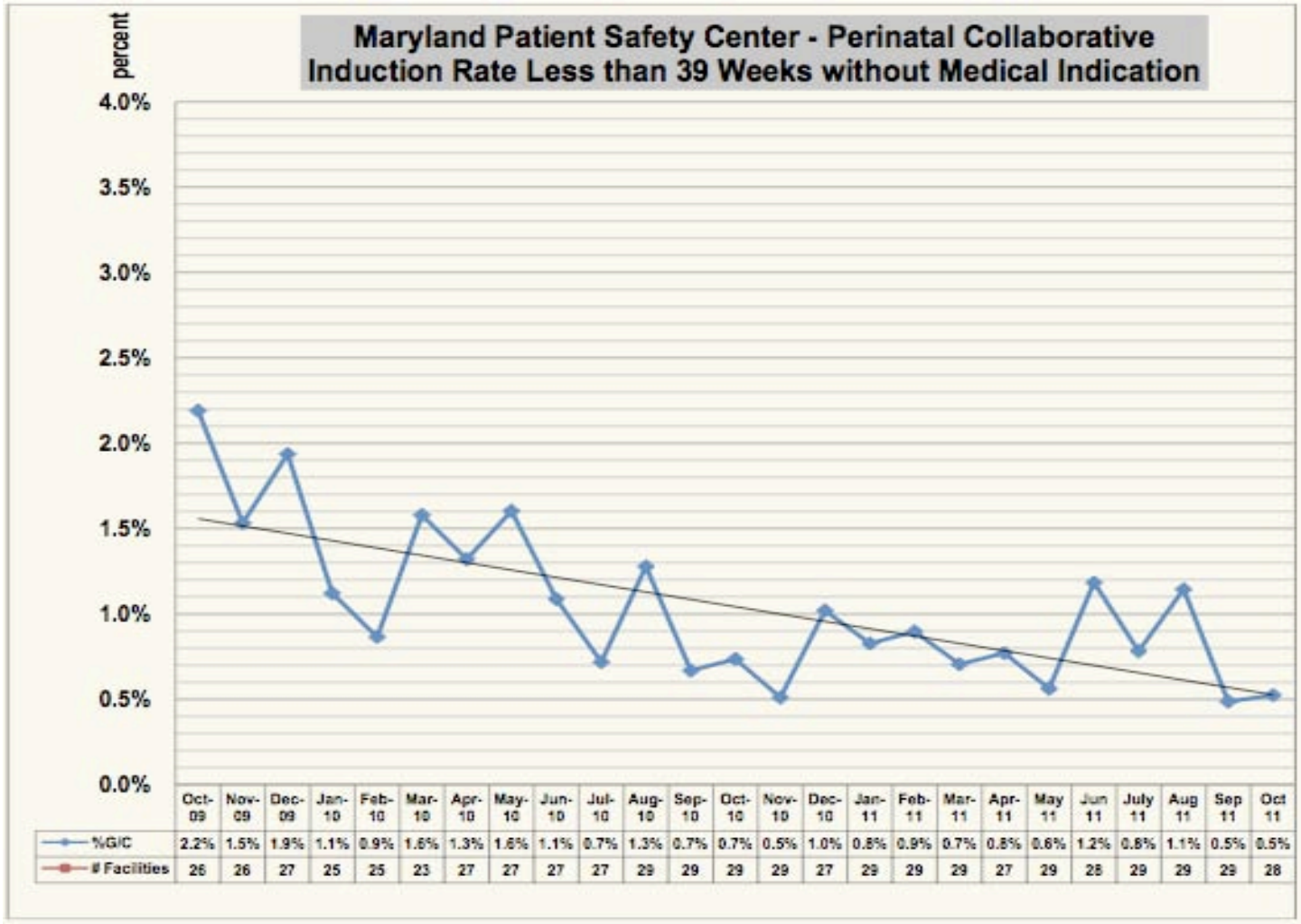
Purpose: Reduce elective inductions and c-sections prior to 39 weeks without medical indication; Improve neonatal outcomes; Standardize the discharge process for mothers and infants including the late pre-term infant



Details: Perinatal/Neonatal Collaborative

Collaborative	Focus
Perinatal Collaborative	•Launched in 2007 •Initial funding by Dept of Health and Mental Hygiene •30 of 34 Maryland birthing hospitals, touching 90% of births in the state •Aim: reduce infant harm through integration of systems improvements and team behaviors into maternal-fetal care; Create perinatal units that deliver care safely and reliably with zero preventable adverse events
Neonatal Collaborative	•Launched in 2009 •Initial funding by CareFirst BlueCross BlueShield •26 birthing hospitals from MD, DC and VA •Aim: improve neonatal outcomes by reducing neonatal morbidity, mortality and cost of care. Includes using standardized resuscitation and stabilization of the neonate in the first hour of life -- the "golden hour" and improving teamwork and communication through use of team behaviors, including the family, in neonatal care
Perinatal/Neonatal Learning Network	•Merged in 2012 •32 of 34 Maryland birthing hospitals •Aim: Standardize the discharge process for mothers and infants including the late pre-term infant

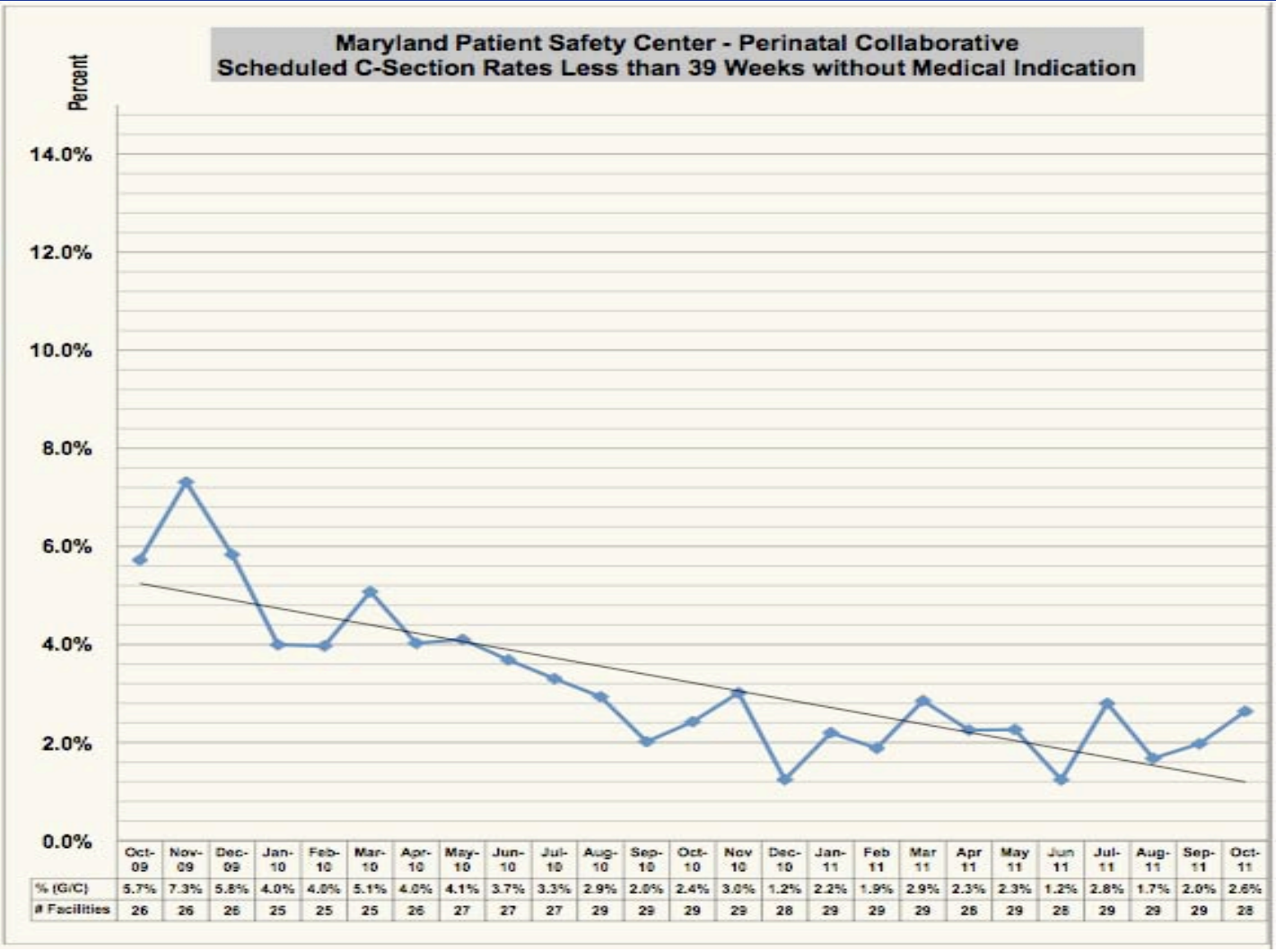
Results:
Inductions <39 Weeks w/o Medical Indication



Results: Inductions <39 Weeks w/o Medical Indication

Inductions			
Audit of Inductions to Determine Medical Necessity	Total Inductions	Number of Inductions < 39 weeks without a medical indication	Rate < 39 weeks without a medical indication
Month	Number	Number	% (G/C)
Oct 09	1324	29	2.2%
Nov 09	1175	18	1.5%
Dec 09	1291	25	1.9%
Q4 09	**3790**	**72**	**1.9%**
Jan 10	1161	13	1.1%
Feb 10	1157	10	0.9%
Mar 10	1267	20	1.6%
Q1 10	**3585**	**43**	**1.2%**
Apr 10	1212	16	1.3%
May 10	1248	20	1.6%
Jun 10	1380	15	1.1%
Q2 10	**3840**	**51**	**1.3%**
July 10	1254	9	0.7%
Aug 10	1330	17	1.3%
Sep 10	1350	9	0.7%
Q3 10	**3934**	**35**	**0.9%**
Oct 10	1225	9	0.7%
Nov 10	1177	6	0.5%
Dec 10	1276	13	1.0%
Q4 10	**3678**	**28**	**0.8%**
Jan 11	1089	9	0.8%
Feb 11	1115	10	0.9%
Mar 11	1277	9	0.7%
Q1 11	**3481**	**28**	**0.8%**
Apr 11	1169	9	0.8%
May 11	1245	7	0.6%
Jun 11	1339	15	1.1%
Q2 11	**3753**	**31**	**0.8%**
July 11	1155	9	0.8%
Aug 11	1234	14	1.1%
Sep 11	1236	6	0.5%
Oct 11	1147	6	0.5%

Results:
C-Sections <39 Weeks w/o Medical Indication



	Oct-09	Nov-09	Dec-09	Jan-10	Feb-10	Mar-10	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov 10	Dec-10	Jan-11	Feb 11	Mar 11	Apr 11	May 11	Jun 11	Jul-11	Aug-11	Sep-11	Oct-11
% (G/C)	5.7%	7.3%	5.8%	4.0%	4.0%	5.1%	4.0%	4.1%	3.7%	3.3%	2.9%	2.0%	2.4%	3.0%	1.2%	2.2%	1.9%	2.9%	2.3%	2.3%	1.2%	2.8%	1.7%	2.0%	2.6%
# Facilities	26	26	26	25	25	25	26	27	27	27	29	29	29	29	28	29	29	29	28	29	28	29	29	29	28

Results:
C-Sections <39 Weeks w/o Medical Indication

C-Section			
Audit of Scheduled C-Sections to Determine Medical Necessity	Total Scheduled C-Section	Number of scheduled C-Sections<39 weeks without a medical indication	Rate < 39 weeks without a medical indication
Month	Number	Number	% (G/C)
Oct 09	769	44	5.7%
Nov 09	670	49	7.3%
Dec 09	720	42	5.8%
Q4 09	**2159**	**135**	**6.3%**
Jan 10	651	26	4.0%
Feb 10	605	24	4.0%
Mar 10	788	40	5.1%
Q1 10	**2044**	**90**	**4.4%**
Apr 10	845	34	4.0%
May 10	683	28	4.1%
Jun 10	842	31	3.7%
Q2 10	**2370**	**93**	**3.9%**
July 10	757	25	3.3%
Aug 10	784	23	2.9%
Sep 10	744	15	2.0%
Q3 10	**2285**	**63**	**2.8%**
Oct 10	743	18	2.4%
Nov 10	664	20	3.0%
Dec 10	722	9	1.2%
Q4 10	**2129**	**47**	**2.2%**
Jan 11	637	14	2.2%
Feb 11	584	11	1.9%
Mar 11	701	20	2.9%
Q1 11	**1922**	**45**	**2.3%**
Apr 11	621	14	2.3%
May 11	663	15	2.3%
Jun 11	644	8	1.2%
Q2 11	**1928**	**37**	**1.9%**
July 11	714	20	2.8%
Aug 11	775	13	1.7%
Sep 11	709	14	2.0%
Oct 11	645	17	2.6%

Results: "Golden Hour" Measures

MARYLAND Patient Safety CENTER

Golden Hour Measures				
	Baseline 7/1/09 -9/30/09	10/1/09 - 9/30/10 (Rolling 12 mos)	10/1/10 - 11/30/11 (Rolling 12 months)	Goal
Pulse Oximetry (Reported Monthly)	24%	38% (58% improvement over baseline)	49% (104% improvement over baseline)	80%
1-Hour Surfactant (Reported Monthly)	81%	85% (5% improvement over baseline)	86% (6%improvement over baseline)	100%
Axillary Temperature (Reported Monthly)	36%	20% (44% improvement over baseline)	13% (64% improvement over baseline)	0%
Average Initial LOS (Reported Monthly)	20 days	15 days (25% reduction from baseline)	31 days (55% increase over baseline)	10% relative reduction from baseline
1-Hour Antibiotics (Reported Monthly)	36%	30% (17% decline from baseline)	56% (56% improvement over baseline)	100%
1-Hour Surfactant (Reported Monthly)	81%	85% (5% improvement over baseline)	86% (6% improvement over baseline)	100%
	Baseline 1/1/09 - 6/30/09	7/1/09 - 6/30/10 (Rolling 12 mos)	7/1/10 - 6/30/11	
Chronic Lung Disease (Reported Quarterly)	15%	11% (27% reduction from baseline)	7% (53% reduction from baseline)	10% relative reduction from baseline
Mortality Rate (Reported Quarterly; results are per 100 live births meeting gest. age criteria in study)	5 per 100	6 per 100*	5 per 100	10% relative reduction from baseline

* Change not statistically significant using Fisher's Exact Test. P = 0.707134

Results:
AHRQ Culture of Safety Survey

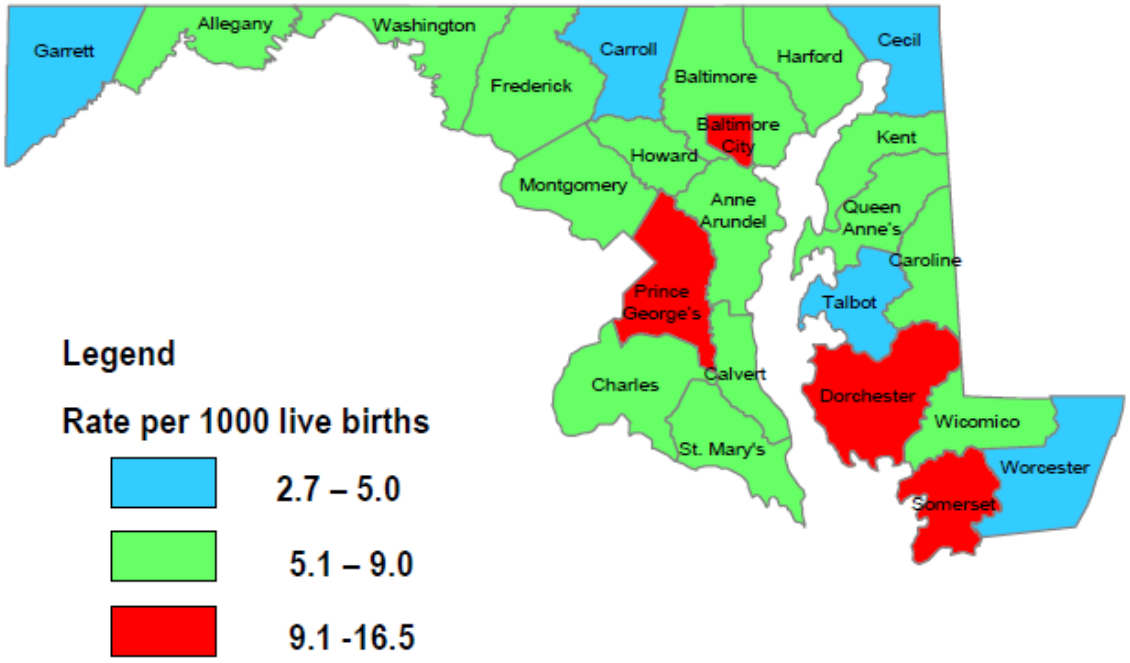
(Survey of process improvement by Perinatal/Neonatal Collaborative participants)

	2011 Combined Collaborative AHRQ Survey Average	AHRQ 2012 User Comparative Database Report – OB Unit	2009 Perinatal Collaborative AHRQ Survey Average	2009 Neonatal Collaborative AHRQ Survey Average
Overall Perceptions of Safety	75%	64%	62%	65%
Frequency of Reported Events	82%	63%	59%	54%
Supervisor/Manager Expectations & Actions Promoting Safety	84%	73%	73%	74%
Organizational Learning - Continuous Improvement	90%	72%	73%	75%
Teamwork within Units	90%	81%	82%	86%
Communication Openness	79%	61%	60%	62%
Feedback and Communication About Error	82%	62%	58%	56%
Non-punitive Response to Error	53%	41%	39%	43%
Staffing	77%	61%	63%	67%
Hospital management support for patient safety	82%	69%	69%	69%
Teamwork Across Hospital Units	75%	58%	56%	55%
Hospital Handoffs & Transitions	71%	56%	52%	52%

Area of Focus – FY13

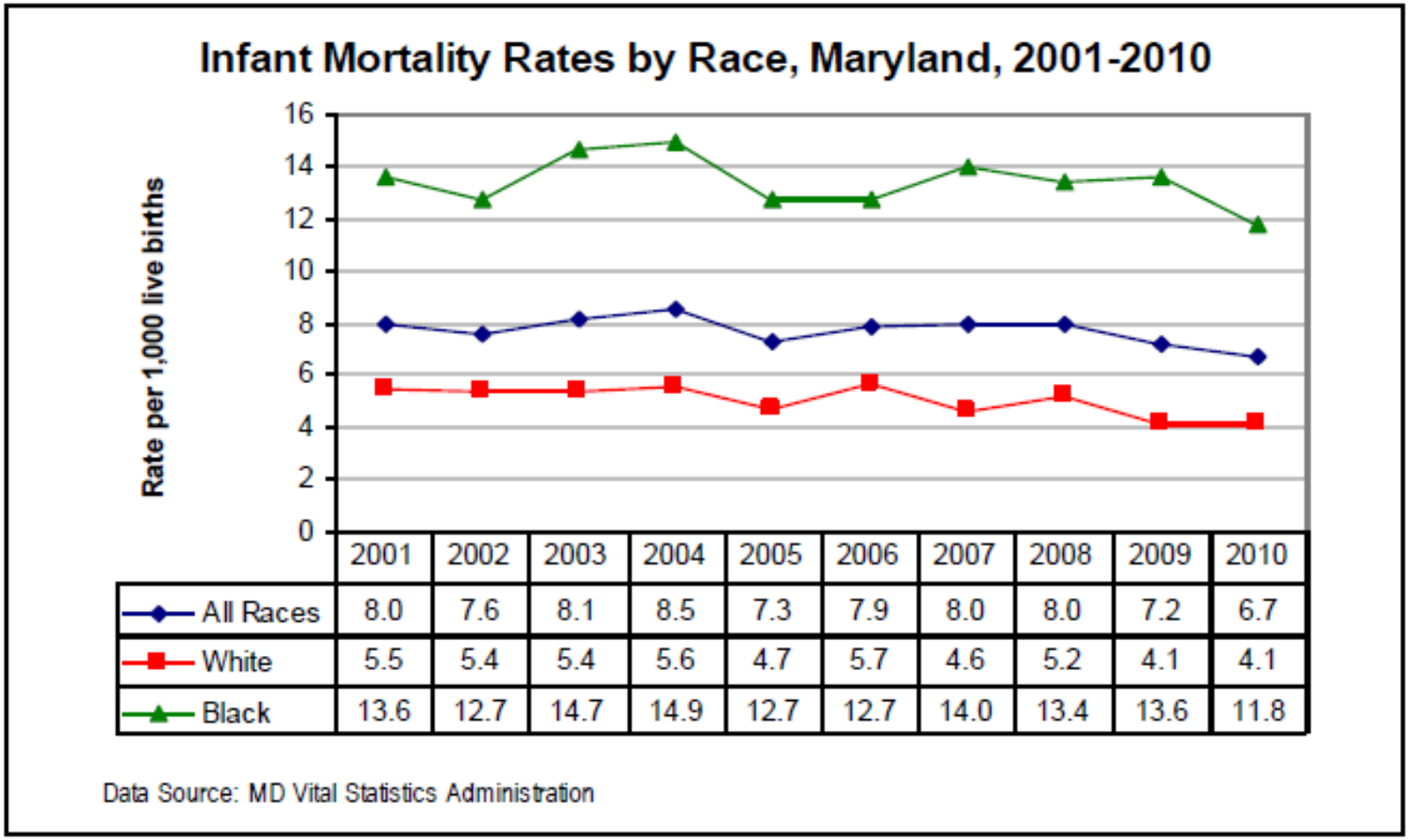
Geographic Disparity in Maryland

Average Infant Mortality Rate, By Jurisdiction, 2005-09



Data Source: MD Vital Statistics Administration

Racial Disparity in Infant Mortality



	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
All Races	8.0	7.6	8.1	8.5	7.3	7.9	8.0	8.0	7.2	6.7
White	5.5	5.4	5.4	5.6	4.7	5.7	4.6	5.2	4.1	4.1
Black	13.6	12.7	14.7	14.9	12.7	12.7	14.0	13.4	13.6	11.8

Data Source: MD Vital Statistics Administration

Next Steps: Perinatal/Neonatal Collaborative

- Risk assessment for all mothers and infants and referral to appropriate providers or services:
  - 8 of Maryland's 24 counties identified as containing "Communities At-Risk"
  - Maryland's maternal mortality rate (20.5 per 100,000 live births) is 30% higher than the national rate (15.8 per 100,000 live births)
  - The percent of live births that are very preterm is more than twice as high for blacks than for whites or Hispanics
  - Despite success in lowering the overall infant mortality rate between 2009 and 2010, the "Infant Mortality in Maryland 2010" report identifies five counties at risk with significant disparities between white and black mothers and infants
- Focus on new measures:
  - Percent of maternal & neonatal discharges where risk assessment was completed
  - Percent of records where risk was demonstrated and there is a referral to a community provider/health department
  - Percent of patients determined to have risk factors where referral was completed and kept scheduled appointment

SAFE from FALLS Collaborative

Maryland Patient Safety Center

Purpose: Reduce the incidence and severity of patient and resident falls in hospital, nursing home and home health settings in Maryland

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

Details:
SAFE from FALLS Collaborative

- Launched in 2008
- 30 hospitals, 20 long term care facilities and 6 home health care providers participating
- Organizations participate in collecting data on falls, education and best practices for preventing falls
- Participants engage in a falls management program and a patient/resident care bundle

Fall Management Program

S – Safety coordination

A – Accurate and concurrent reporting

F – Facility expectations, staff education

E – Education for patients and families

Patient/Resident Care Bundle

F – Falls risk screening

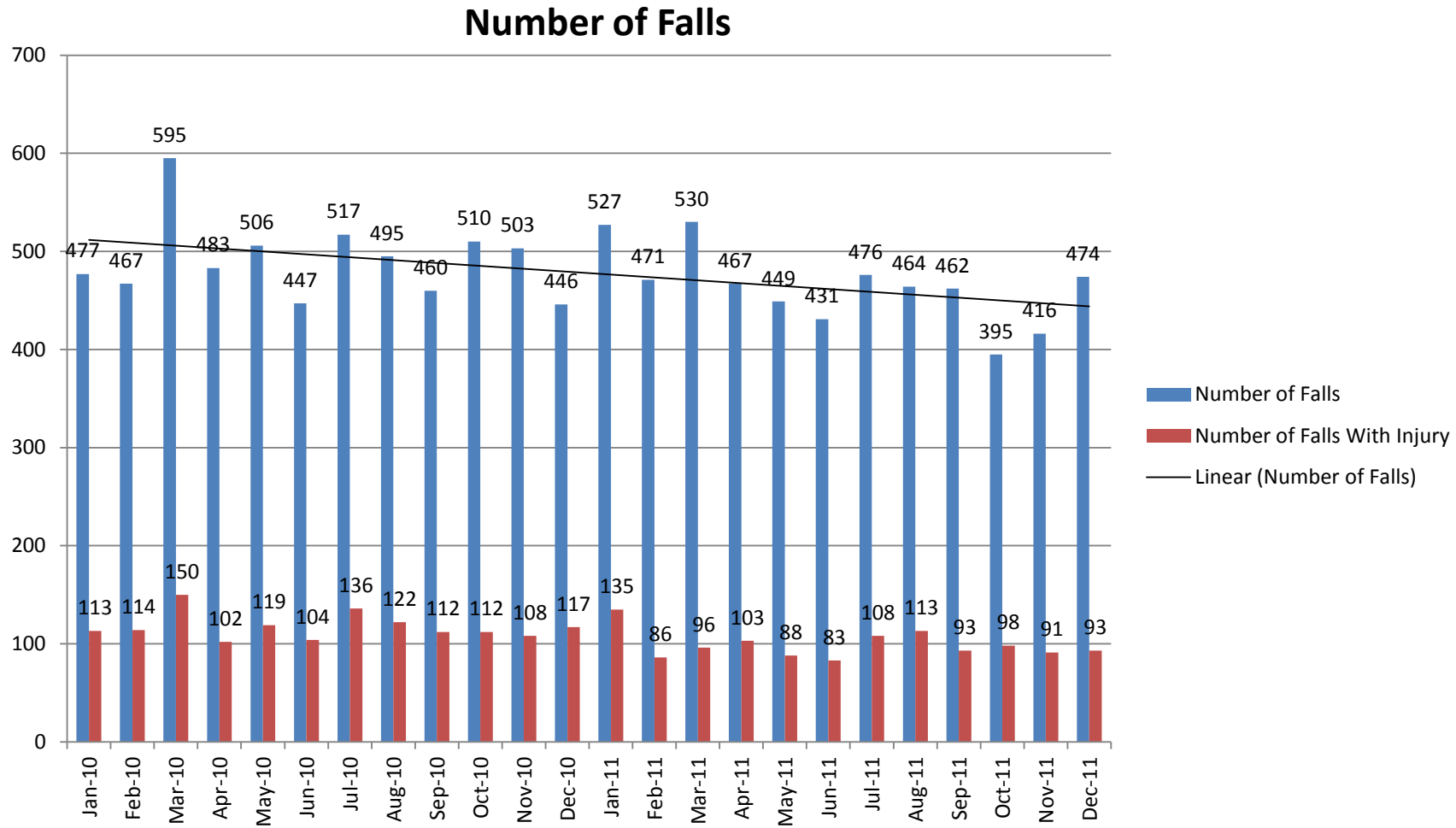
A – Assessment of risk factors

L – Linked interventions

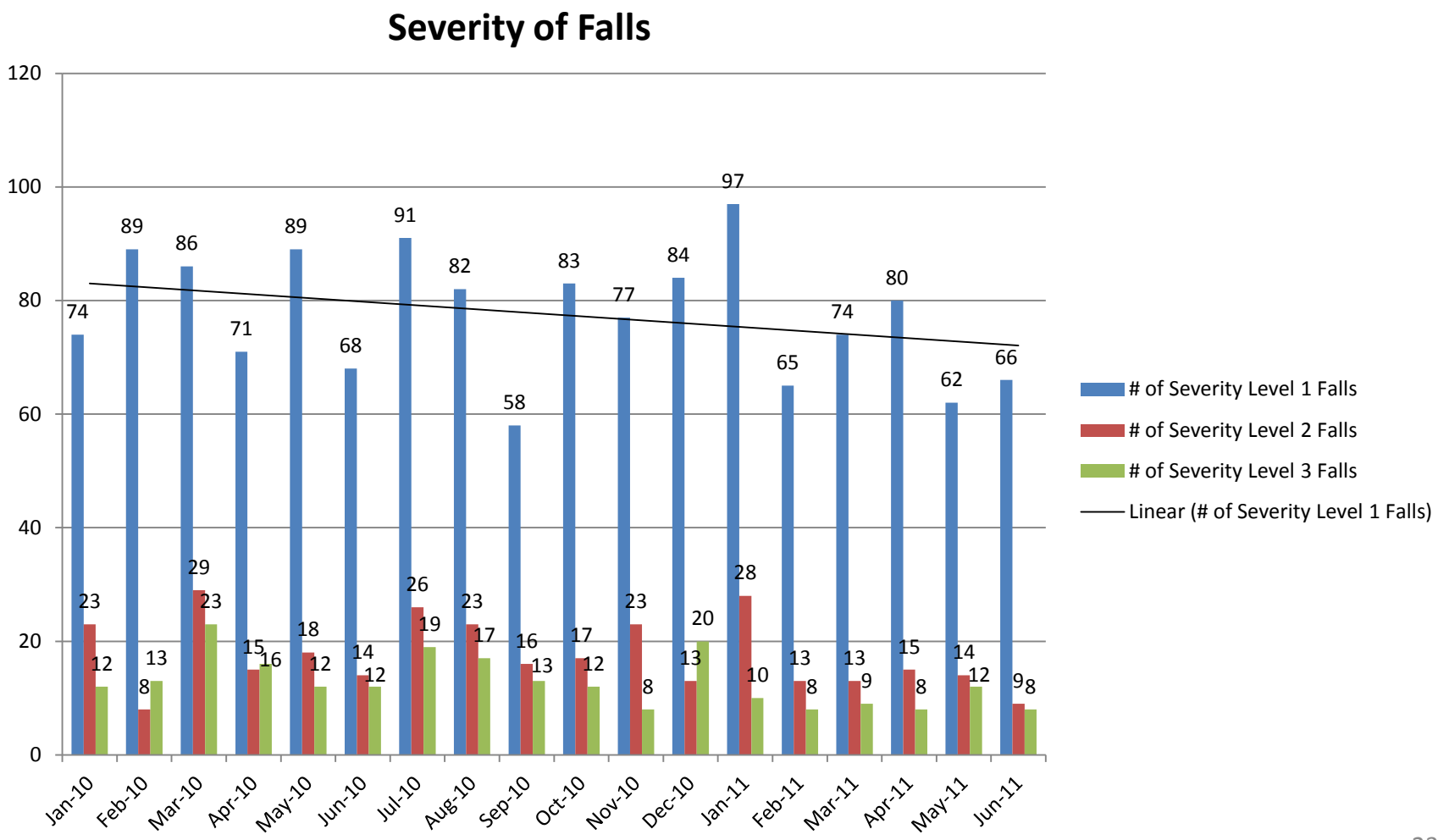
L – Learn from events

S – Safe environment

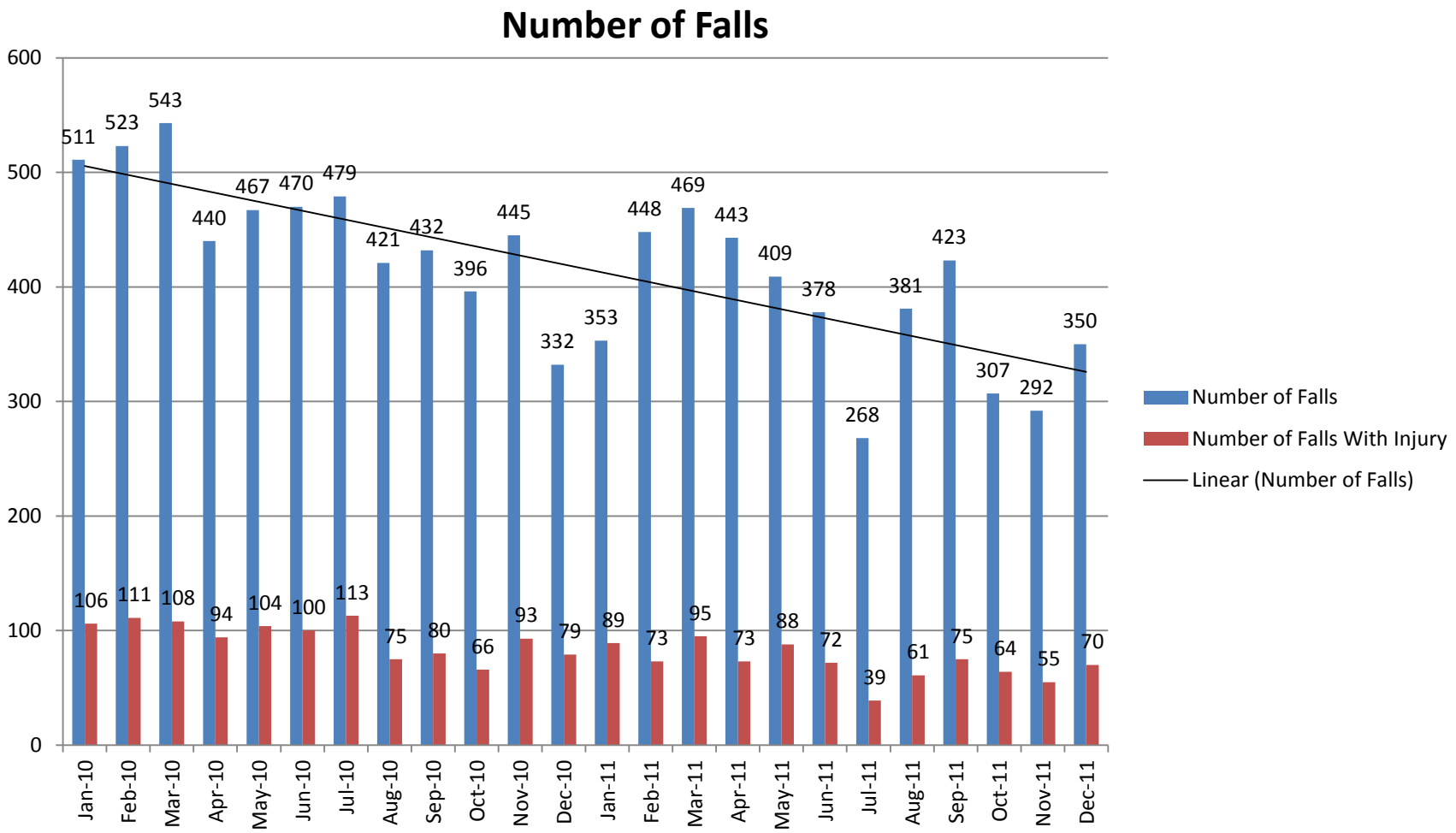
Results:
SAFE from FALLS Acute Care



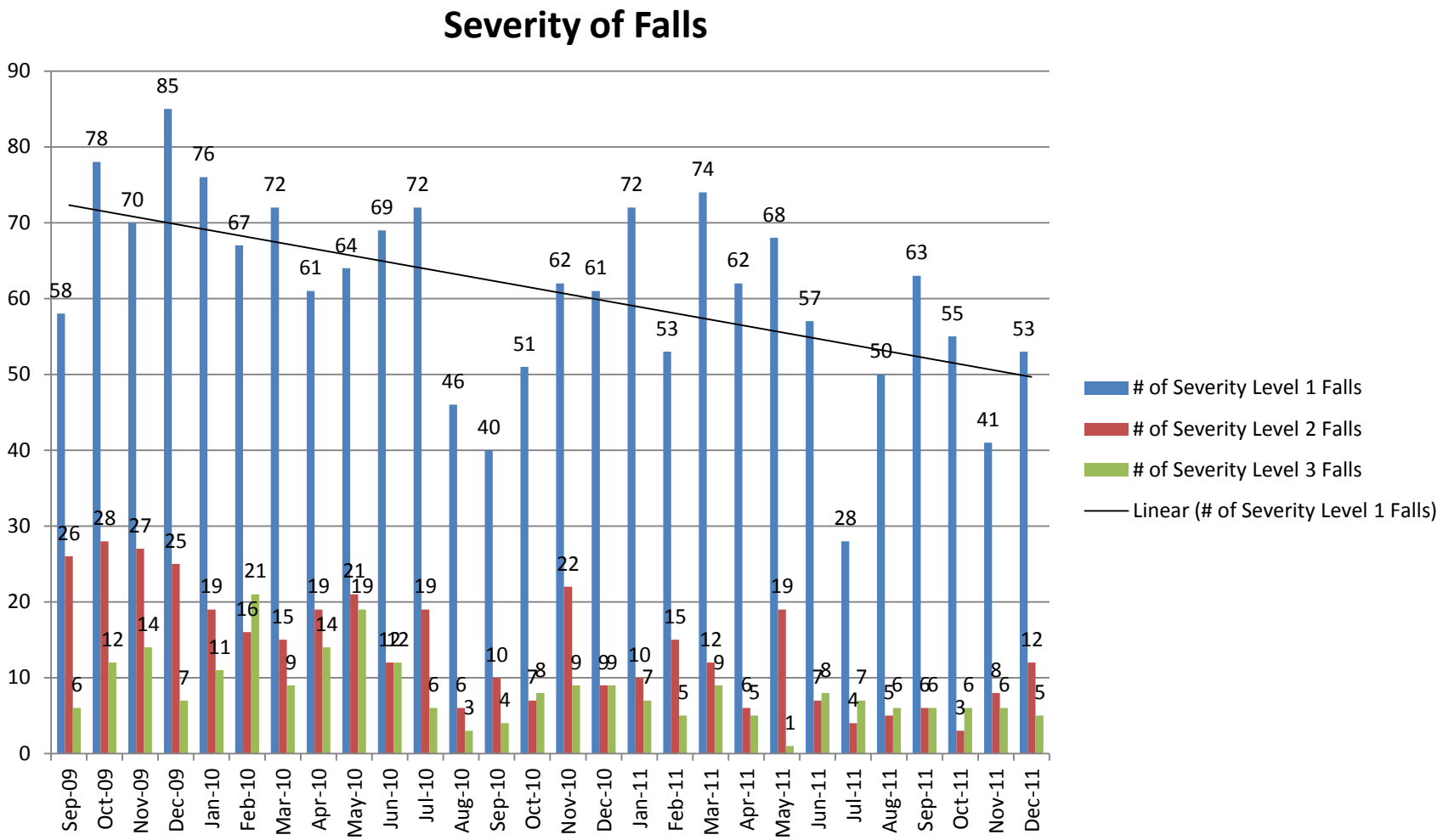
Results:
SAFE from FALLS Acute Care



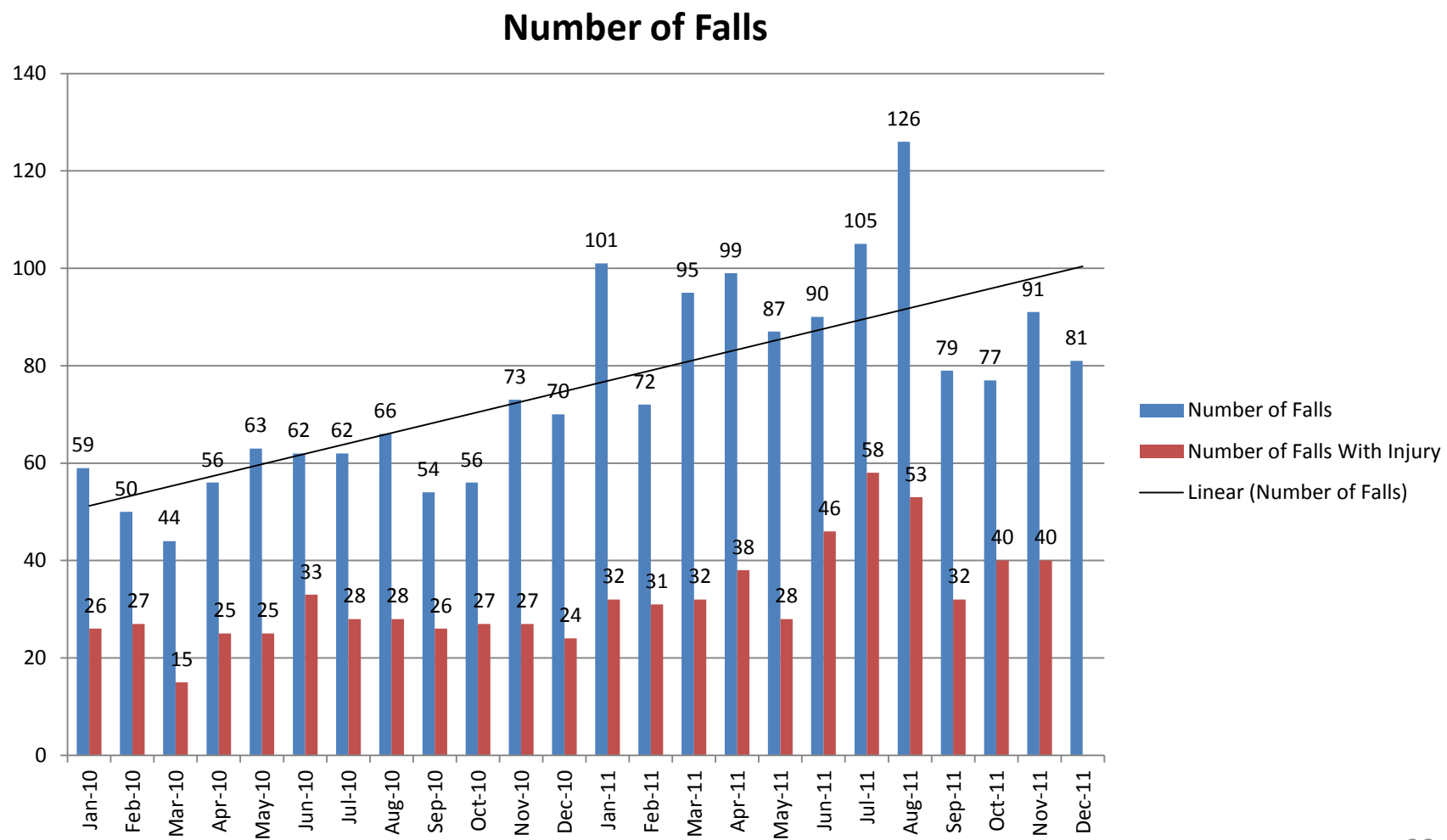
Results:
SAFE from FALLS Long Term Care



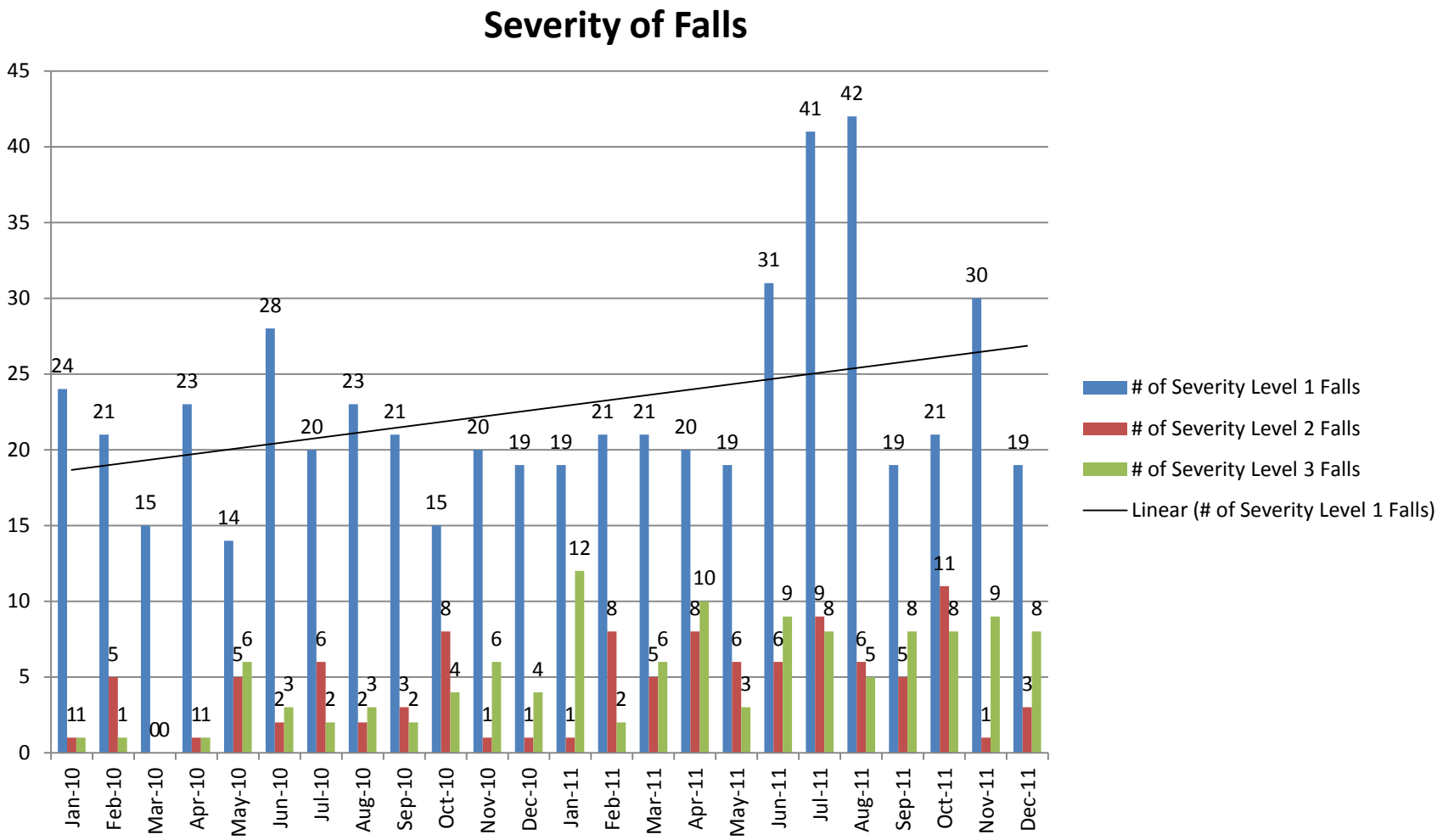
Results:
SAFE from FALLS Long Term Care



Results:
SAFE from FALLS Home Health



Results:
SAFE from FALLS Home Health



Results:
SAFE from FALLS – Numbers of Falls

	Maryland Hospital Falls Prevented	Cost Prevented
2010	324	$2,193,156
2011	641	$4,338,929
To Date	965	$6,532,085

Estimated cost of acute care fall: $6,769*

*Keeping Patients SAFE from FALLS Initiative, Methods of Projecting Cost of Falls based on data from four quarters of data, 2010: Vahe A. Kazandjian PhD, MPH, Principal, ARALEZ Health LLC, and Wendy Gary, VP Healthcare Quality and Patient Safety, Delmarva Foundation for Medical Care

Results:
SAFE from FALLS – Severity of Falls

Level	Reduction in 2011 Compared to 2010
Level I – Injuries involving little or no care	15%
Level 2 – Injuries requiring some medical care	55%
Level 3 –Injuries clearly requiring medical intervention	29%

Year	Ratio: No Harm to Harm
2010	2.98 (2.98 falls with no harm for every fall with harm)
2011	3.64 (3.64 falls with no harm for every fall with harm)

Next Steps: SAFE from FALLS

- Increase hospital participation to 100%
- Increase nursing home participation to 50%
- 10% reduction in aggregate fall rate across all participants
- 10% reduction in severity of falls across all participants

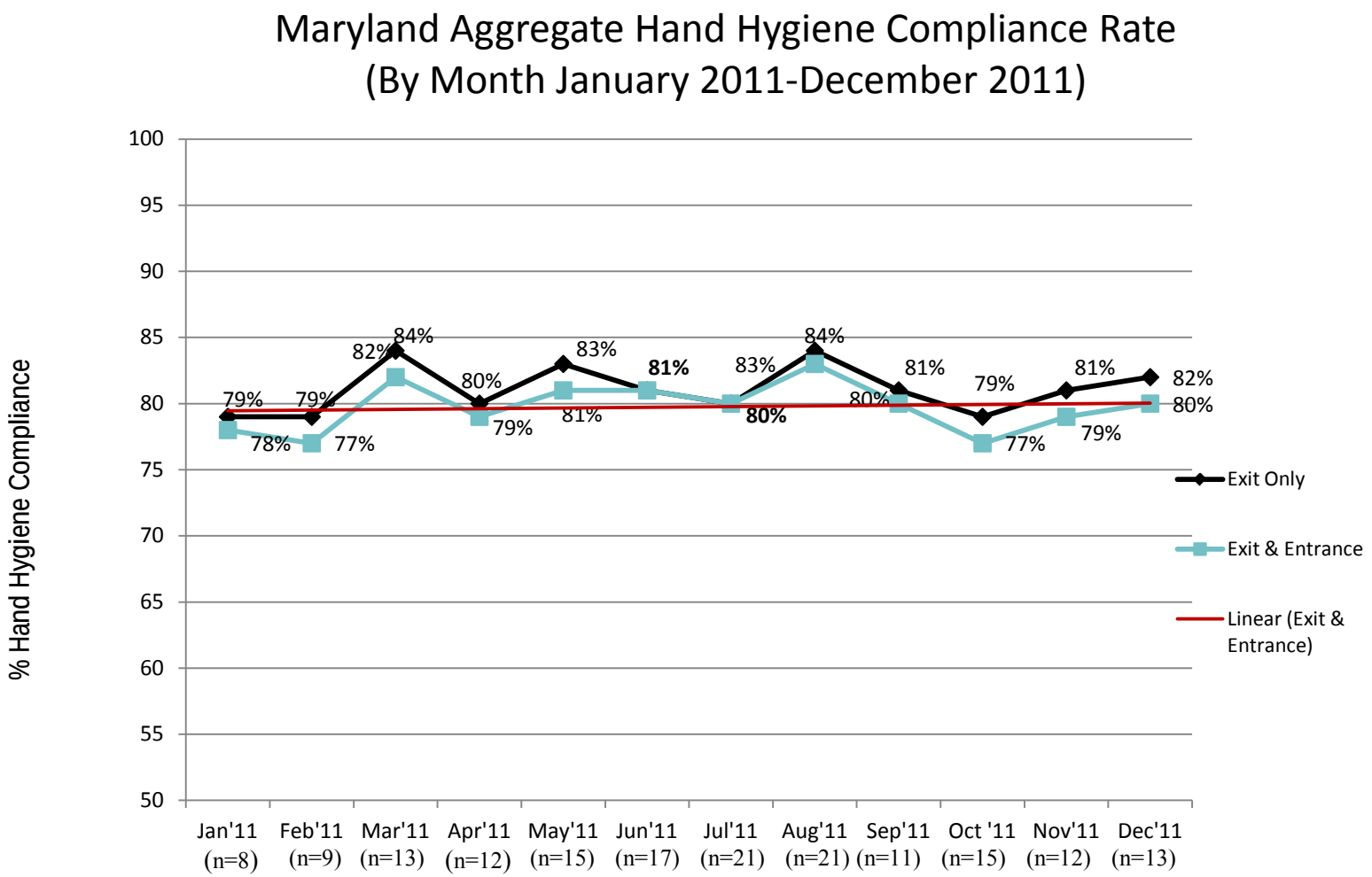
Hand Hygiene Collaborative

Purpose: Reduce preventable infections in Maryland hospitals through better hand hygiene (first statewide effort of its kind in the nation)

Details:
Hand Hygiene Collaborative

- Participating hospitals use unknown observers to record hand cleansing upon exit or entry from patient rooms. Hospitals are to collect 30 observations each month from at least 80 percent of the units required by the Collaborative
- 30 of 46 acute care hospitals are participating with 9 more recently signed on
- The Collaborative is led by the Maryland Patient Safety Center with assistance from the Delmarva Foundation and the Maryland Hospital Association
- Important partners include the Maryland Healthcare Quality and Cost Council, who initiated the idea, and the Maryland Department of Health and Mental Hygiene

Early Results: Hand Hygiene Collaborative



N = number of hospitals meeting the 80/30 rule

Next Steps: Maryland Hand Hygiene Collaborative

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

Adverse Event Reporting

Purpose: The Maryland Patient Safety Center provides hospitals with the ability to report adverse events through ECRI adverse event reporting system

Hospitals may choose a Patient Safety Organization with whom to submit and analyze adverse event data on a confidential basis. Seven hospitals to date report and analyze their adverse event data through the Maryland Patient Safety Center

MEDSAFE

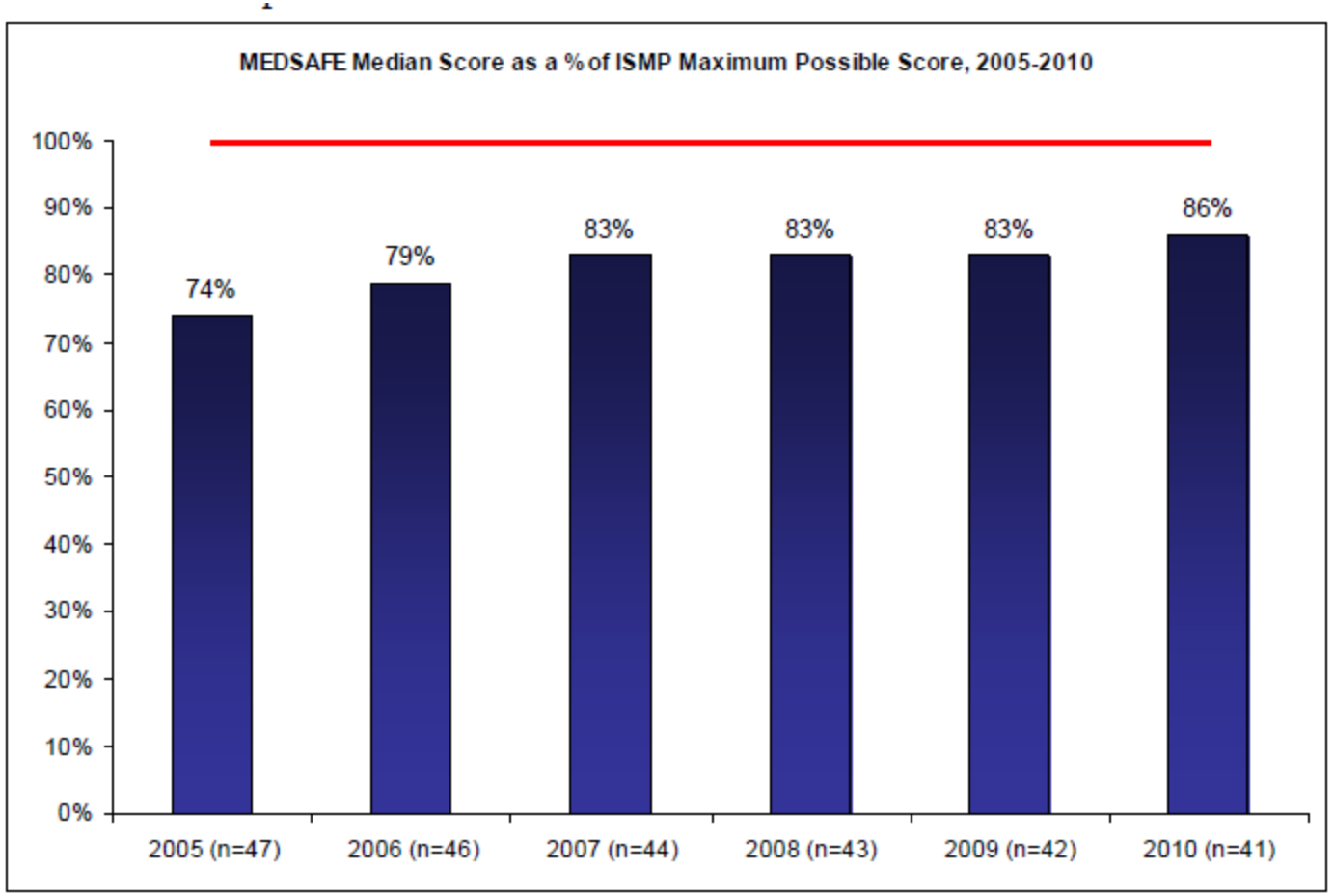
Purpose: to systematically assess the processes that hospitals have in place to ensure the safe use of medications

- Medication errors are the most common type of serious adverse event
- Since 2004, 97 serious (Level I) medication errors have been reported to the Office of Health Care Quality
- The death rate for all serious adverse events in Maryland in 37%. The death rate for medication errors is 68%; another 20% suffered a long term or permanent brain injury

Details: MEDSAFE

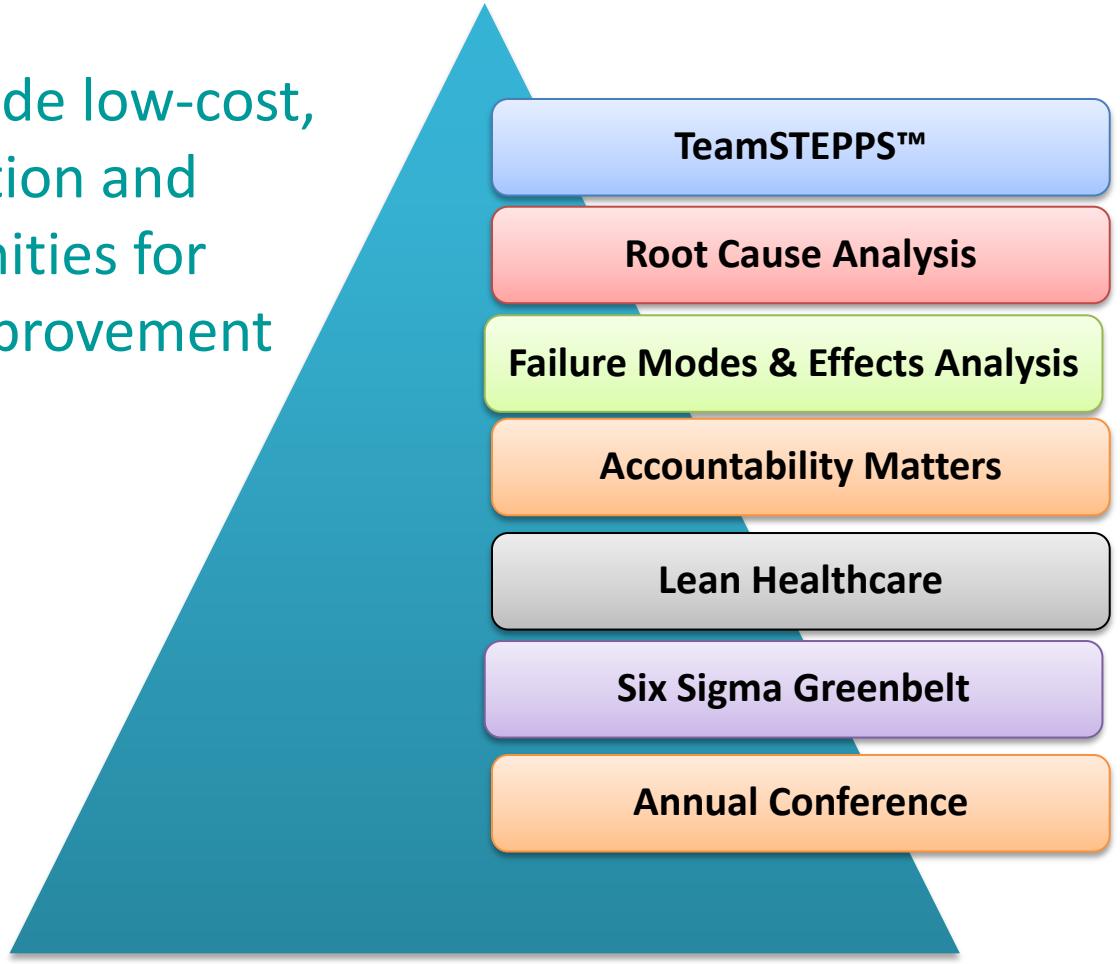
- MEDSAFE was launched in 2000
- MEDSAFE participants use the Institute for Safe Medication Practices (ISMP) Safety Self-Assessment® to assess the safety of medication practices within their organization
- In 2012, 42 of 46 hospitals in Maryland completed the ISMP self-assessment survey
- On an annual basis, aggregate results are analyzed and shared with hospitals to allow for statewide comparisons
- Results from the survey, particularly improvement opportunities, are shared and discussed at the Annual MEDSAFE Conference. In 2012, the Conference had its largest-ever attendance with 220 professionals, including pharmacists, medication safety officers, nursing professionals and quality & safety leaders and addressed topics including:
  - Using ISMP Self-Assessment Results for Medication Safety Improvements
  - Improving Staff Education & Competency
  - Using an Active Surveillance System as a Risk Identification Strategy
  - Reducing Hospital Readmissions Related to Medication Use
  - National Drug Shortages

Results: MEDSAFE



Education Offerings

Purpose: To provide low-cost, accessible education and training opportunities for patient safety improvement



Results: Education & Training

Education Programs	FY12			Cumulative	
	Participants	Hospitals	Average Evaluation (4.0 scale)	Participants	Hospitals
TeamSTEPPS™	55	10	3.6	342	55
Root Cause Analysis	113	34	3.7	641	67
Failure Modes Effects Analysis	28	14	3.8	401	64
Accountability Matters	33	17	*	171	38
Lean Healthcare	41	18	3.61	412	52
Six Sigma Greenbelt	46	18	3.69	265	49
Annual Conference	1230	63	*	4848	81

* Programs scheduled but not yet held in FY12

FY 2013 Budget

MARYLAND Patient Safety CENTER

REVENUE

Cash Contributions from MHA/Delmarva	400,000
Cash Contributions from Hospitals	300,000
Cash Contributions for LTC/HC	100,000
HSCRC Funding	1,225,637
Restricted Grant- DHMH	250,000
Education Session Revenue	373,000
Interest Income	
Total Revenue	**2,648,637**

EXPENSES

Administration		1,030,561
Adverse Event Reporting System		83,100
Restricted Perinatal Collaborative		250,000
Outpatient Dialysis (previously committed)		75,000
Programs:		
Hand Hygiene Collaborative	208,662	
Perinatal (unrestricted)	186,335	
Safe From Falls	215,607	
Website Support	17,872	
Annual Patient Safety Conference	280,000	
Education Sessions	313,000	
Team STEPPS (LTC)	25,000	
MEDSAFE Conference	38,500	
Total Programs		1,284,976
Total Expenses		**2,723,637**
Net Loss		**(75,000)**

FY 2013 Budget Key Assumptions

- The Maryland Patient Safety Center received $2 million in proposals to prevent harm with budget to fund $1 million of projects

- Assumes HSCRC funding continues at 45% of Maryland Patient Safety Center expenses

- Assumes any balances left at the end of the year are retained by the Maryland Patient Safety Center

Outpatient Revenue Constraint Mechanism

Planning and Timeline - April 11, 2012

Objectives

Last month, the Commission suspended the Charge Per Visit (CPV) methodology for FY 2012. The Commission charged HSCRC staff with developing and implementing new or modified outpatient constraint mechanisms. HSCRC staff will recommend to the Commission an interim constraint mechanism to apply in FY 2013. During FY 2013, HSCRC staff will develop, test, and recommend a longer-term outpatient constraint mechanism with the intent to implement in FY 2014.

Parameters

The HSCRC intends for the interim outpatient constraint mechanism to be methodologically straight-forward and targeted at observed areas of outpatient volume/revenue growth. The longer-term outpatient constraint mechanism aims to establish bundling, or other mechanisms, to encourage efficiency.

Timeline

HSCRC staff developed a preliminary timeline, see Table 1, for planning, development, and implementation of an outpatient revenue constraint mechanism.

Table 1: Outpatient Revenue Constraint Mechanism Planning, Development, and Implementation - Preliminary Timeline

	FY 12			FY13												FY 14											
	04	05	06	07	08	09	10	11	12	01	02	03	04	05	06	07	08	09	10	11	12	01	02	03	04	05	06
Planning and Data Analysis																											
• Analyze outpatient revenue growth drivers																											
• Present objectives and timeline to Commission																											
Interim Outpatient Constraint Mechanism																											
• Develop interim outpatient constraint mechanism																											
• Recommend interim constraint mechanism																											
• Implement interim constraint mechanism																											
• Monitor impact of interim constraint mechanism																											
Outpatient Constraint Mechanism																											
• Develop and test outpatient constraint options																											
• Recommend constraint mechanism																											
• Implement constraint mechanism																											
• Monitor impact of constraint mechanism																											

Legislative Update – April 11, 2012

SB 150 - FY 2013 Medicaid Budget

The FY 13 Medicaid budget assumes that the Medicaid deficit assessment will increase by $24 million, from $389 million in FY 12 to $413 million in FY 13. In addition, the Medicaid Budget assumes that Medicaid cost containment measures relating to hospitals will save an additional $75 million in Medicaid costs, as follows:

- Tiering Outpatient Clinic and Emergency Services - $30 million General Funds (GF), $60 million total funds
- Pooling Disproportionate Share - $9.1 million GF, $18.2 million total
- Reducing Payment for Medically Needy Population - $36 million GF, $72 million total

In all, the Medicaid budget assumes additional savings and assessments/remittances from hospital-related policies of $99 million ($24 million in additional Medicaid Deficit Assessment + $75 million in cost containment measures).

The Medicaid budget also assumes that the HSCRC annual update factor will be 3.8% on inpatient services, and 4.65% on outpatient services, for a combined increase of 4.13%. If the Commission adopts an update factor that is less than 4.13%, Medicaid would achieve savings. These savings could be applied to the $99 million savings/additional assessments required in the budget. For each 1% below 4.13%, Medicaid is expected to achieve State savings of $14 million.

A Department of Legislative Services (DLS) recommended budget would have removed $14 million from this potential savings. DLS's recommendation, in essence, reduces the assumed update factor from 4.13% to 3.13%. Thus, if the Commission adopted an update factor of 3.13%, under this analysis, it could not apply that $14 million to reduce the other cost containment provisions. Given the stresses on the waiver test, the Commission will be compelled to undertake cost containment measures that have an impact on the waiver projections. Therefore, the recommended action would prevent the Commission from using this amount to make a small improvement in the waiver test.

SB 150 passed without the proposed $14 million hospital-related cut. Therefore, any savings to Medicaid resulting for an update factor lower than 4.13% can be applied to the cost containment measures and additional Medicaid deficit assessment.

SB 152 – Budget Reconciliation and Financing Act of 2012 (BRFA)

The BRFA bill adds language to HSCRC statute to permit the Commission, as is currently permitted for uncompensated care costs, to adopt alternative methods of financing the reasonable costs of "disproportionate share hospital payments". This concept was intended to permit the Commission to pool DSH costs to achieve the $9 million in related savings discussed above (in SB 150).

The BRFA bill did not pass before the General Assembly adjourned Sine Die. As a result, the Commission does not obtain the authority to adopt this pooling mechanism, and the related $9.1 million in expected Medicaid savings is not required. Barring any further legislative action (in a Special Legislative Session), the total hospital-related cost containment now stands at $66 million - $30 million from tiering of certain outpatient services, and $36 million from reducing payments for the medically needy population (see above). If a Special Session is convened, this could change.

SB 953 and HB 1341 - Medicaid Sustainability Commission

Senate Bill 953 and House Bill 1341 would create a Medicaid Sustainability Commission to study and make recommendations on:

- Current Medicaid funding sources;
- Short-term and long-term funding needs of Medicaid
- Short-term and long-term options to reduce the growth in Medicaid costs; and
- Short-term and long-term options for sustainable revenue sources for Medicaid, including revenue measures that will negatively impact the Medicare waiver or federal provider tax laws.

The bill requires that the recommendations of the new Commission to have the impact of increasing State general funds for Medicaid by at least the amount of the Medicaid Deficit Assessment.

Neither bill passed out of committee.

SB 234 - Maryland Health Improvement and Disparities Reduction Act of 2012

This Administration bill establishes a process for designation of "Health Enterprise Zones" (HEZs) to target State resources to reduce health disparities, improve health outcomes, and reduce health costs and hospital admissions and readmissions in specific areas of the State. The bill authorizes specified incentives for "Health Enterprise Zone practitioners" who practice in an HEZ, including tax credits against the State income tax. The bill also establishes a Health Enterprise Zone Reserve Fund.

As it relates to the HSCRC, the bill requires hospitals to submit with their annual community benefit report a description of a hospital's efforts to track and reduce health disparities in the community that the hospital serves.

In addition, the HSCRC and MHCC are required to study the feasibility of including racial and ethnic performance data tracking in quality incentive programs, and to report data by race and ethnicity in quality incentive program, where feasible, to the General Assembly by January 1, 2013.

The bill passed and was signed by the Governor on April 10.

HB 443 - Maryland Health Benefit Exchange Act of 2012

This Administration bill expands the operating structure of the Maryland Health Benefit Exchange by, among other things, authorizing the exchange to contract with health insurance carriers in a certain manner, establishing the framework for the Small Business Health Options Program (SHOP) Exchange, and establishing navigator programs for the SHOP and Individual exchanges. The bill requires SHOP Exchange navigators to be licensed, Individual Exchange navigators to be certified, and insurance producers to be authorized to sell qualified plans in the SHOP and/or Individual exchanges. The bill also establishes a process for selecting the benchmark plan that will serve as the standard for the essential health benefits for health benefit plans offered in the small group and individual markets, both inside and outside the exchange.

The Bill also establishes a joint legislative and executive committee which includes the chair of the HSCRC (or the chair's designee). The committee is created to study and report on financing mechanisms which should be used to enable the Exchange to be self-sustaining by 2015. An amendment added to the bill required that any recommendation should consider the impact of any funding mechanism on health insurance premiums and the State's Medicare waiver.

The bill passed the General Assembly

Title 10 DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Subtitle 37 HEALTH SERVICES COST REVIEW COMMISSION

Chapter 10 Rate Application and Approval Procedures

Authority: Health-General Article, §§ 19-207, 19-211; Annotated Code of Maryland

NOTICE OF PROPOSED ACTION

The Health Services Cost Review Commission proposes to amend Regulations **.26** under **COMAR 10.37.10 Rate Application and Approval Procedures**. This action was considered and approved for promulgation by the Commission at a previously announced open meeting held on April 11, 2012, notice of which was given pursuant to State Government Article, § 10-506(c), Annotated Code of Maryland. If adopted, the proposed amendments will become effective on or about August 14, 2012.

Statement of Purpose

The purpose is to notify hospital inpatients and outpatients of the potential for separate bills for hospital and physician services provided at the hospital.

Comparison of Federal Standards

There is no corresponding federal standard to this proposed action.

Estimate of Economic Impact

The proposed action has no economic impact.

Opportunity for Public Comment

Comments may be sent to Diana M. Kemp, Regulations Coordinator, Health Services Cost Review Commission, 4160 Patterson Avenue, Baltimore, Maryland 21215, or (410) 764-2576, or fax to (410) 358-6217, or email to dkemp@hscrc.state.md.us. The Health Services Cost Review Commission will consider comments on the proposed amendments until May 21, 2012. A hearing may be held at the discretion of the Commission.

.26 Patient Rights and Obligations; Hospital Credit and Collection and Financial Assistance Policies.

A. Hospital Information Sheet.

(1)(a)-(d) (text unchanged)

(e) Includes a statement that physician charges, *to both hospital inpatients and outpatients,* are *generally* not included in the hospital bill and are billed separately.

(2) – (4) (text unchanged)

JOHN M. COLMERS
Chairman
Health Services Cost Review Commission

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

John M. Colmers
Chairman

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

Joseph R. Antos, Ph.D.

George H. Bone, M.D.

Jack C. Keane

Bernadette C. Loftus, M.D.

Thomas R. Mullen

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Patrick Redmon, Ph.D.
Executive Director

Stephen Ports
Principal Deputy Director
Policy and Operations

Gerard J. Schmith
Deputy Director
Hospital Rate Setting

Mary Beth Pohl
Deputy Director
Research and Methodology

TO: Commissioners

FROM: Legal Department

DATE: April 4, 2012

RE: Hearing and Meeting Schedule

Public Session:

May 2, 2012 1:00 p.m., 4160 Patterson Avenue, HSCRC Conference Room

June 6, 2012 1:00 p.m., 4160 Patterson Avenue, HSCRC Conference Room

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

The Agenda for the Executive and Public Sessions will be available for your review on the Thursday before the Commission meeting on the Commission's website.
www.hscrc.state.md.us/commissionMeetingSchedule2012.cfm

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