STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

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490th MEETING OF THE HEALTH SERVICES COST REVIEW COMMISSION
July 11, 2012

EXECUTIVE SESSION
9:00 a.m.

1. **Waiver Issues**
2. **Legislative Audit**

PUBLIC SESSION OF THE
HEALTH SERVICES COST REVIEW COMMISSION
9:30 a.m.

1. **Review of the Executive Session and Public Meeting Minutes of the June 6, 2012 Meeting**

2. **Executive Director's Report**

3. **Docket Status – Cases Closed**

   2157N – Levindale Hospital
   2158N – Civista Medical Center
   2159N – Civista Medical Center
   2161A – Johns Hopkins Health System
   2162A – Johns Hopkins Health System

4. **Docket Status – Cases Open**

   2160N – Maryland General Hospital
   2163A – Johns Hopkins Health System
   2164N – Calvert Memorial Hospital
   2165A – University of Maryland Medical Center
   2166A – University of Maryland Medical Center
   2167A – Johns Hopkins Health System

5. **Final Recommendation regarding FY 11 Averted Bad Debt Reconciliation, Reconciliation Policy Beginning FY 2012, and Addressing Net Cost Containment Amounts related to the FY 13 Medicaid Budget**

6. **Final Recommendation on continuance of, and future modifications to, the Nurse Support I Program**

7. **Report on Outpatient Cost and Volume Trends**

8. **Legal Report**

9. **Hearing and Meeting Schedule**

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

AS OF JUNE 28, 2012

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

Docket Number	Hospital Name	Date Docketed	Decision Required by:	Rate Order Must be Issued by:	Purpose	Analyst's Initials	File Status
2160N	Maryland General Hospital	5/15/2012	7/14/2012	10/12/2012	CHR,RDS,REC	GS	OPEN
2163A	Johns Hopkins Health System	5/30/2012	N/A	N/A	ARM	DNP	OPEN
2164N	Calvert Memorial Hospital	6/12/2012	7/12/2012	11/9/2012	MRI	CK	OPEN
2165A	University of Maryland Medical Center	6/12/2012	N/A	N/A	ARM	DNP	OPEN
2166A	University of Maryland Medical Center	6/12/2012	N/A	N/A	ARM	DNP	OPEN
2167A	Johns Hopkins Health System	6/12/2012	N/A	N/A	ARM	DNP	OPEN

PROCEEDINGS REQUIRING COMMISSION ACTION - NOT ON OPEN DOCKET

IN RE: THE PARTIAL RATE	*	**BEFORE THE HEALTH SERVICES**	
APPLICATION OF MARYLAND	*	**COST REVIEW**	
GENERAL HOSPITAL	*	**DOCKET:**	**2012**
	*	**FOLIO:**	**1970**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2160N**

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Staff Recommendation - Approved

July 11, 2012

Introduction

On May 1, 2012, Maryland General Hospital ("MGH," or the "Hospital") filed a partial rate application with the Maryland Health Services Cost Review Commission (HSCRC) requesting the establishment of three new rates for Chronic Care (CHR), Respiratory Dependent Care (RDS), and Recreational Therapy (REC) to be effective July 1, 2012.

MGH, James Lawrence Kernan Hospital ("Kernan"), and University Specialty Hospital ("USH") are members of the University of Maryland Medical System ("UMMS"). USH currently has 180 licensed Chronic Care beds . UMMS has decided to relocate 80 of these beds to MGH; relocate 24 of these beds to Kernan; and de-license the remaining 76 chronic care beds. This would effectively end inpatient services at USH on July 11, 2012. Kernan already has a Chronic Care rate; therefore, no additional rates are required at Kernan. However, MGH does not have rates for the requested three centers.

Staff Evaluation and Recommendation

The Hospital has requested approval of rates that would be equal to the January 1, 2012 statewide median for these rate centers plus approved inflation for FY 2013. The Hospital has assumed inflation would be -1% for these inpatient revenue centers.

The Hospital is requesting a rate of $792.74 per day for CHR, $791.93 per day for RDS, and $81.90 per Relative Value Unit (RVU) for REC. The current rates at USH are $485.22 per day for CHR, $610.02 per day for RDS, and $82.73 per RVU for REC. At the requested rates, MGH would generate approximately $5.3 million more than USH is currently generating. Under Commission policy, a hospital receives the lesser of its estimated cost or the statewide median rate. Therefore, staff reviewed the cost reported by USH for FY 2011 (the last year for which a cost report was filed.)

This produced a rate of $459.54 for CHR, $1,003.69 for RDS, and $302.91 for REC. A further review of the FY 2011 cost report revealed that certain costs were misclassified. After correcting the misclassified cost and adjusting for the proper FY 2013 Update Factors, the staff recommends the following rates at MGH effective July 11, 2012; provided the Hospital receives the necessary approval from the Maryland Health Care Commission for the relocation of the beds:

	Approved Rate	Units of Service	Approved Revenue
Chronic Care	$478.10	14,164	$6,771,852
Respiratory Dependent	$1,002.23	5,209	$5,220,630
Recreational Therapy	$84.02	582	$48,902

These rates represent the lesser of the requested rates or the rates based on USH's realigned rates after correcting for misclassified cost. Since these cases are not included under the Commission's Charge Per Episode Agreement ("CPE") with MGH, no further adjustment is necessary at this time.

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION	*	**COMMISSION**	
JOHNS HOPKINS HEALTH	*	**DOCKET:**	**2012**
SYSTEM	*	**FOLIO:**	**1973**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2163A**

Staff Recommendation - Approved

July 11, 2012

I. INTRODUCTION

Johns Hopkins Health System (“System”) filed an application with the HSCRC on May 30, 2012 on behalf of Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center (the Hospitals) for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System requests approval from the HSCRC to continue to participate in a global rate arrangement for solid organ and bone marrow transplants services with INTERLINK Health Services, Inc. The System requests approval for a period of one year beginning July 1, 2012.

II. OVERVIEW OF APPLICATION

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

III. FEE DEVELOPMENT

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

IV. IDENTIFICATION AND ASSESSMENT OF RISK

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

V. STAFF EVALUATION

Although there has been no activity under this arrangement, staff believes that the Hospitals can achieve a favorable experience under this arrangement.

VI. STAFF RECOMMENDATION

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

IN RE: THE PARTIAL RATE	*****	**BEFORE THE HEALTH SERVICES**
APPLICATION OF	*****	**COST REVIEW COMMISSION**
CALVERT MEMORIAL	*****	**DOCKET: 2012**
HOSPITAL	*****	**FOLIO: 1974**
PRINCE FREDERICK, MARYLAND	*****	**PROCEEDING: 2164N**

Staff Recommendation - Approved

July 11, 2012

Introduction

On June 12, 2012, Calvert Memorial Hospital (the "Hospital") submitted a partial rate application to the Commission for a rate for Magnetic Resonance Imaging (MRI) services to be provided to both inpatients and outpatients. This new rate will replace the Hospital's currently rebundled MRI rate. A rebundled rate is approved by the Commission when a hospital provides certain non-physician services to inpatients through a third-party contractor off-site. By approving a rebundled rate, the Commission makes is possible for a hospital to bill inpatients for the services provided off-site, as required by Medicare. However, as of July 1, 2012, the Hospital will be providing MRI on-site to both inpatients and outpatients. The Hospital requests that the rate be set at the lower of a rate based on its projected costs to provide MRI services or the statewide median rate and be effective July 1, 2012.

Staff Evaluation

To determine if the Hospital's MRI rate should be set at the state wide median or at a rate based on its own costs, Staff requested that the Hospital submit its cost and statistical data for MRI services. Based on information received, Staff determined that the MRI rate based on the Hospital's cost data would be $36.45 per RVU, while the statewide median rate for MRI services is $42.25 per RVU.

Recommendation

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

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 MRI rate of $36.45 per RVU be approved effective July 1, 2012;
3. That the MRI rate not be rate realigned until a full year's cost experience data have been reported to the Commission.

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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: 1975**
BALTIMORE, MARYLAND	*	**PROCEEDING: 2165A**

Staff Recommendation - Approved

July 11, 2012

I. INTRODUCTION

University of Maryland Medical Center (the Hospital) filed an application with the HSCRC on June 12, 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 liver and blood and bone marrow transplants for a period of one year with Cigna Health Corporation beginning July 1, 2012.

II. OVERVIEW OF APPLICATION

The contract will be held and administered by University Physicians, Inc. ("UPI"), which is a subsidiary of the University of Maryland Medical System. UPI will manage all financial transactions related to the global price contract including payments to the Hospital and bear all risk relating to services associated with the contract.

III. FEE DEVELOPMENT

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

IV. IDENTIFICATION AND ASSESSMENT OF RISK

The Hospital will 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 between UPI and the Hospital holds the Hospital harmless from any shortfalls in payment from the global price contract.

V. STAFF EVALUATION

The staff found that the Hospital's experience under this arrangement for the previous year was favorable.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission: 1) waive the requirement that an application be filed 30 days prior to the effective date of an alternative rate determination arrangement; and 2) approve the Hospital's application for an alternative method of rate determination for liver and blood and bone marrow transplant services, for a one year period commencing July 1, 2012. The Hospital will need to file a renewal application to be considered for continued participation.

Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the 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.

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:**	**1976**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2166A**

Staff Recommendation - Approved

July 11, 2012

I. INTRODUCTION

University of Maryland Medical Center (UMMC, or "the Hospital) filed a renewal application with the HSCRC on June 12, 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 the collection of peripheral blood stem cells from donors for a period of one year with the National Marrow Donor Program (NMDP) beginning July 1, 2012.

II. OVERVIEW OF APPLICATION

The NMDP, which coordinates the donation, collection, and transplantation of stem cells and bone marrow from unrelated donors for patients without matching donors in their families, will continue to use UMMC as a collection site for Department of Defense donors. The contract will continue to be held and administered by University Physicians, Inc. (UPI), which is a subsidiary of the University of Maryland Medical System. UPI will continue to manage all financial transactions related to the contract including payments to the Hospital and bear all risk relating to services associated with the contract.

III. FEE DEVELOPMENT

The technical portion of the global rates was developed based on historical hospital charge data relative to the collection of peripheral stem cells. The remainder of the global rate is comprised of physician service costs.

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 between UPI and the Hospital holds the Hospital harmless from any shortfalls in payment from the global price contract.

V. STAFF EVALUATION

The staff reviewed the experience for the last year under this arrangement and found that it was favorable.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission: 1) waive the requirement that an

application be filed 30 days prior to the effective date of an alternative method of rate determination arrangement; and 2) approve the Hospital's application for an alternative method of rate determination for the collection of peripheral stem cells for one year commencing July 1, 2012. The Hospital will need to file another renewal application for review to be considered for continued participation. Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospital for the approved contract. This document will formalize the understanding between the Commission and the Hospital, and will include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION	*	**COMMISSION**	
JOHNS HOPKINS HEALTH	*	**DOCKET:**	**2012**
SYSTEM	*	**FOLIO:**	**1977**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2167A**

Staff Recommendation - Approved

July 11, 2012

I. INTRODUCTION

Johns Hopkins Health System (the "System") filed an application with the HSCRC on June 14, 2012 on behalf of Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center (the Hospitals) for an alternative method of rate determination, pursuant to COMAR 0.37.10.06. The System requests approval from the HSCRC to continue to participate in a global rate arrangement for solid organ and bone marrow transplant services with MultiPlan, Inc. for a period of one year beginning July 1, 2012.

II. OVERVIEW OF APPLICATION

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

III. FEE DEVELOPMENT

The hospital portion of the new global rates was developed by calculating mean historical charges for patients receiving solid organ and bone marrow transplant services at the Hospitals. The remainder of the global rate is comprised of physician service costs. Additional per diem payments were calculated for cases that exceed a specific length of stay outlier threshold.

IV. IDENTIFICATION AND ASSESSMENT OF RISK

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

V. STAFF EVALUATION

Although there has been no activity under this arrangement, staff continues to believe that the Hospitals can achieve a favorable experience under this arrangement.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission: 1) waive the requirement that alternative applications be filed 30 days before the proposed effective date; and 2) approve the Hospitals' application for an alternative method of rate determination for solid organ and bone marrow transplant services, for a one year period commencing July 1, 2012. The Hospitals will need to file a renewal application for review to be considered for continued participation. Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospitals for the approved contract. This document would formalize the understanding between the Commission and the Hospitals, and would include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.

Averted Bad Debt:
FY 2011 Reconciliation of Averted Bad Debt Estimates to Actual and Averted Bad Debt Policies for FY 2012 and Beyond

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

July 11, 2012

These final recommendations were approved at the Public Commission Meeting on July 11, 2012.

Purpose

This paper provides recommendations related to the reconciliation of averted bad debt estimates to actual for FY 2011. This recommendation also proposes policies related to reconciling the Medicaid expansion uniform assessment in FY 2012 and beyond.

HSCRC staff has engaged Maryland Medicaid, hospital, and payer representatives to discuss averted bad debt reconciliation. Our process has included discussions with the individual parties, provision of hospital discharge data and uncompensated care to Medicaid, review of information provided by Maryland Medicaid, and the facilitation of in-person meetings among the interested parties.

FY 2011

Similar to FY 2010, the amount of "actual" averted bad debt in FY 2011 is less than the amount paid by hospitals to Maryland Medicaid. Based on the reconciliation assumptions discussed later in this paper, the final averted bad debt reconciliation amount is $18.1 million.

In determining this final averted bad debt reconciliation amount for FY 2011, HSCRC staff recommends:

1. Projecting the final claims run-out amount for June 2012 based on the charges in May 2012,
2. Retaining the crowd out rate used in the FY 2010 settlements at 18.22 percent; reducing the lower use rate adjustment factor to 9 percent, and
3. Reducing the future assessment payments to the Department by $18.1 million.

FY 2012

Before FY 2012, Maryland Medicaid and the HSCRC calculated the amount of averted bad debt to be built into rates based on expected amounts of program expenditures for the upcoming fiscal year. As the program reached a near steady-state, changes to State statute implemented for FY 2012 rates locked the amount of revenue allocated for the Medicaid expansion at uniform assessment of 1.25 percent of projected regulated net patient revenue for each hospital.[1] With a fixed percentage built into rates, policy no longer requires HSCRC staff to reconcile expected to actual averted bad debt between the hospitals and Maryland Medicaid. However, the Maryland Hospital Association (MHA) and hospital representatives have expressed interest in continuing the claim-specific reconciliation for use in calculating the HSCRC's uncompensated care provision in FY 2012.

Recent Commission Actions

The most recent Commission action regarding averted bad debt was on October 12, 2011 involving the reconciliation of averted bad debt estimates to actual for FY 2010.

[1] Health - General Article 19-214(d)(2)(i)

Background

In 2007, the General Assembly enacted Chapter 7 of the Laws of Maryland, The Working Families and Small Business Health Coverage Act (The 2007 Act), which expands access to health care in a number of ways, including expanding Medicaid eligibility to parents and caretaker relatives with household income up to 116 percent of the federal poverty guidelines (FPG), an increase from 46 percent FPG, beginning in FY 2009. A component of the 2007 Act also provided for Board of Public Works actions in July 2009 to add emergency services to Medicaid's Primary Adult Care (PAC) program, a program that provides a limited benefit package of health services to non-parental adults. Special funds, including savings from averted uncompensated care, cover a portion of the costs of these expansions.

FY 2011 Reconciliation

Determination of the Averted Bad Debt Assessment Amount in FY 2011

When establishing the FY 2011 hospital rates, HSCRC staff worked with Maryland Medicaid staff to arrive at a total amount of bad debt that was expected to be averted during the upcoming fiscal year as a result of the Medicaid expansion. Maryland Medicaid provided HSCRC staff with expected enrollment, per member/per month costs, and total expenditures. Commission staff then adjusted the expected total Medicaid expansion expenditure amount to reflect out-of-state admissions, the estimated percentage of Medicaid expansion expenditures that would accrue to hospitals (as opposed to other providers or service components), the crowd-out rate, and the lower use rate.

The product of this calculation resulted in a total amount that HSCRC staff differentially removed from the uncompensated care amounts across all hospitals for FY 2011. The amount removed for each hospital is based on the proportion of Medicaid's expenditures for this type of population at each hospital.

Since State statute requires the assessment to be uniform and broad-based, the Commission added back to the rates of all hospitals an equal percentage that represents the total estimated averted bad debt amount. Any portion that is not added back to rates will reduce rates over all, resulting in savings to purchasers/payers of hospital care. For FY 2011, HSCRC staff calculations built in no savings to purchasers/payers of care in the uniform assessment. Table 1 illustrates the calculations used for establishing the expected averted bad debt and assessment amount for Medicaid and PAC for FY 2011.

Table 1: Medicaid Expansion FY 2011 Expected Averted Bad Debt Calculations (In Millions)

Calculation of Estimated Reduction to Hospital Uncompensated Care		
	Medicaid	**PAC**
DHMH Estimated Expansion Expenditures	$457.6	$25.2
Payments Made Inside of Maryland (Medicaid -6%, PAC 0%)	$430.2	$25.2
Hospital Gross Charges (Medicaid pays 94% of Charges)	$457.6	$26.8
Percent Paid to Maryland Hospitals (Medicaid 47.61%, PAC 100%)	$217.8	$26.8
Medicaid Less: Crowd Out (-28%) and Lower Use Rate (-18%) PAC: No Assumptions	*-$89.2*	*$0*
Hospital Rates Estimated Reduction for Uncompensated Care*	**$128.6**	**$26.8**

Calculation of Payment Made to DHMH	
	Medicaid & PAC
Estimated Reduction to Hospital Rates for Uncompensated Care	$155.4
Savings Provided to Payer (0%)	$0
*Amount Paid to Medicaid (94%)***	**$146.1**

Notes: *Numbers in table may not sum due to rounding*

* A portion of this amount was allocated to each hospital based on the percentage of current Medicaid payments made to the hospital for this type of population. The allocated amount for each hospital was used to calculate a percent of revenue which was then used to reduce each hospital's approved UCC. The reduced UCC was used in each hospital's calculation of approved markup, and Approved Revenue was reduced accordingly.

** A portion of this amount was uniformly allocated to each hospital based on its estimated Approved Revenue for FY 2011. Each hospital made monthly payments to DHMH throughout the year.

*** HSCRC staff calculated the FY 2011 uniform assessment prior to decisions made in October 2011 to alter the crowd out rate assumption from 28% to 18%.

Determining the Total Charges for Medicaid Expansion Population in FY 2011

The reconciliation process is designed to determine the amount that hospitals actually received in payments for the Medicaid expansion population and PAC emergency department service coverage expansion and to calculate the resulting reduction to UCC from these programs. HSCRC staff compares this UCC reduction to the amount that the HSCRC prospectively removed from the UCC component of each hospital's rate to determine any discrepancies between the estimated and actual amounts.

Ideally, HSCRC staff could rapidly ascertain the actual payments for the Medicaid expansion population using one data source. Unfortunately, no one data source provides all information needed for this calculation. Instead, Maryland Medicaid, HSCRC, and hospital staff worked together in an iterative process to supply, compare, and merge data from three major sources. This merging process has proven challenging for all involved.

Due to the timeline to produce rate orders for FY 2013, the timing of this recommendation did not allow HSCRC staff to collect and include data from June 2012 in our final reconciliation calculations. Interested parties discussed the most effective and efficient way to consider the June charges; and, based on these discussions, HSCRC staff recommends using actual claims

from May 2012 to project June 2012 charges. We have included HSCRC staff's projected charges of $1.8 million for June 2012 for Medicaid and PAC throughout this paper.

Applying Crowd Out and Lower Use Rates to Determine Actual Averted Bad Debt in FY 2011

HSCRC staff calculates the actual averted bad debt by applying the crowd out and lower use rate estimates to the expansion population charges from FY 2011. Note that for purposes of this recommendation, we refer to this amount as the "actual" reduction to UCC resulting from the Medicaid expansion. In practice, however, there is a continued amount of estimation involved in the calculation as the crowd-out and lower use rates applied to the total charges are themselves estimates.

Based on our meetings with interested parties, HSCRC staff continued to employ the 18.22 percent crowd out rate agreed upon during the FY 2010 averted bad debt reconciliation.

Maryland Medicaid staff has also discussed the lower use rate with the interested parties. In calculating the estimated reduction to hospital uncompensated care, HSCRC employed a lower use rate of 18 percent. Maryland Medicaid staff advocated eliminating the lower use rate adjustment factor based on an observation that individuals enrolling in the Medicaid expansion eligibility category no longer enter Medicaid with pent up demand. While Medicaid staff did provide data on Medicaid population usage for interested parties to review, HSCRC staff could not disaggregate year-over-year changes observed in the Medicaid expansion population use rates with trends observed in the all-payer population.

However, based on discussion with interested parties, HSCRC staff recommends employing a lower user rate of 9 percent to calculate actual averted bad debt. We use the 9 percent lower use rate adjustment factor in calculations throughout this paper.

Calculation of Overpayments/Underpayments to Maryland Medicaid for FY 2011

Assuming a run-out of $1.8 million, HSCRC staff finds total Medicaid charges in FY 2011 at $144.5. Appling the crowd out rate (18.22 percent) and lower use rate (9 percent), HSCRC staff calculates the actual reduction to bad debt as $107.6 million. For PAC, the FY 2011 charges are $28.7 million. HSCRC staff applies no crowd out or lower use rate assumptions to PAC. As shown in Table 4, the net aggregate difference in what was paid by hospitals to Maryland Medicaid in the form of a uniform assessment, and the amount paid by Maryland Medicaid to hospitals for this population is $18.1 million.

Table 4: Medicaid Expansion FY 2011 Reconciliation of Actual Averted Bad Debt (In Millions)

Calculation of Actual Averted Bad Debt		
	Medicaid	**PAC**
Reduction to Hospital Rates for Uncompensated Care	$158.3	
Total Hospital Charges to the Expansion	$144.5	$28.7
Medicaid Less: Crowd Out (-18.22%) and Lower Use Rate (-9%) PAC: No Assumptions	$43.4	$0
Actual Reduction to Uncompensated Care Due to Expansion	$107.6	$28.7
Calculation of Overpayment/Underpayment to DHMH		
	Medicaid & PAC	
Actual Reduction to Uncompensated Care Due to Expansion	$136.2	
Amount Paid by Medicaid to Hospitals (94%)	$128.0	
Amount Paid to Medicaid by Hospitals	$146.1	
Difference	***$18.1***	

Notes: *Numbers in table may not sum due to rounding*

Options for FY 2011 Reconciliation

Based on the hospital claims reconciliations, HSCRC staff calculated a $18.1 million difference in the FY 2011 actual and assessment amounts associated with averted bad debt for Medicaid and PAC. HSCRC staff recommends reducing future assessment payments to the Department by $18.1 million.

Averted Bad Debt Policy for FY 2012 and Beyond

As discussed in the background section of this recommendation, HSCRC now applies a fixed uniform assessment of 1.25 percent in hospital rates. In FY 2012 and beyond, policy no longer requires reconciliation between Maryland Medicaid and hospitals.

However, HSCRC staff has discussed with interested parties options to settle averted bad debt for use in the UCC calculations in FY 2012 through FY 2014.

MHA and hospital representatives have expressed interest in continuing the claim-specific reconciliation process at least in FY 2012. HSCRC staff will facilitate sending claims from the Department to hospitals to perform the charges reconciliation. In the spring of 2013, HSCRC will apply a run out projection to unreconciled months (likely April, May, and June 2013) and apply the crowd out and lower use rate adjustment factors of 18.22 percent and 9 percent, respectively, to calculate the amount of averted bad debt for FY 2012. At that time, HSCRC staff and MHA will determine if a claim-specific reconciliation is necessary in future years.

Averted Bad Debt Reconciliation Recommendations

For FY 2011, HSCRC staff recommends the Commission settle averted bad debt by:

- Projecting charges for June 2012 using claims from May 2012,

- Changing the lower use rate to 9 percent, and
- Reducing hospital's future assessment payments to the Department by $18.1 million.

For FY 2012, HSCRC staff recommends the Commission:

- Facilitate dissemination of Medicaid expansion claims from the Department to hospitals and
- Apply the crowd out rate and lower use rate used in FY 2011 to calculate actual averted bad debt.

Maryland
Hospital Association

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July 9, 2012

Patrick Redmon, Ph.D.
Executive Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Dr. Redmon:

On behalf of our 66 member organizations, we appreciate the opportunity to provide comment on the staff recommendations regarding reconciliation of averted bad debt for FY 2011, as well as recommendations for handling this important issue for FY 2012 and beyond. This reconciliation has been a challenge for the Health Services Cost Review Commission (HSCRC) staff to address over the past three years, and we commend the staff for their efforts to seek a reasonable approach to finalizing this matter. As we address in greater detail below, there are a number of key assumptions used in the staff recommendations for this reconciliation, which can be challenged, but in the interest of moving forward to address the more pressing concerns regarding Maryland's Medicare waiver, the Maryland Hospital Association (MHA) supports the staff recommendations on averted uncompensated care for 2011 and 2012.

MHA Supports Medicaid Expansion

In July 2008, MHA supported the expansion of Medicaid and the mechanism by which the expansion was funded. Expanded Medicaid coverage reduces uncompensated care and builds on a founding concept of Maryland's all-payor system: ensuring access to care. The Medicaid expansion funding mechanism, as envisioned in July 2008, provided advantages for all the major stakeholders: commercial payors contributed funding and in exchange saw an equivalent reduction in hospital rates in anticipation of reduced uncompensated care; the public benefited from a reduction in the uninsured; and hospitals benefited by having a greater share of their patients covered by insurance. However, implementation of the funding and reconciliation process has been plagued by difficulty measuring the actual uncompensated care averted by the expansion.

Key Assumptions Cannot be Verified

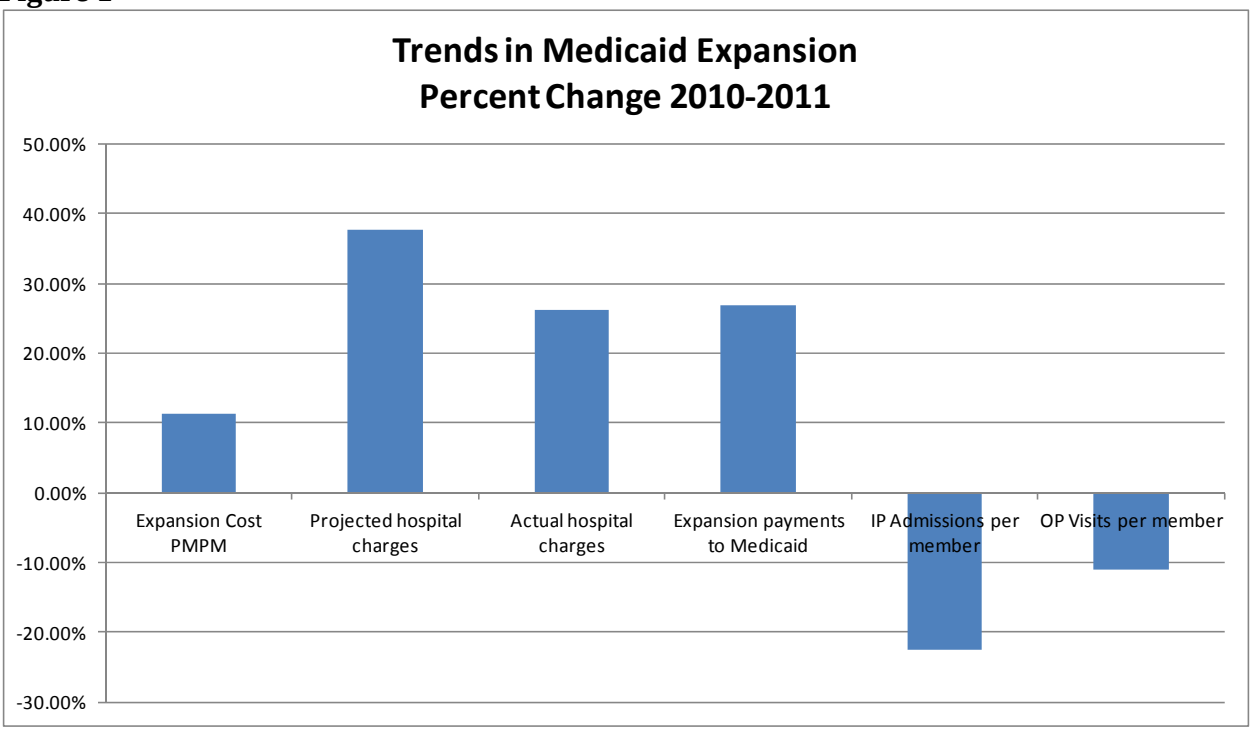
Estimating the amount of averted uncompensated care is inexact and relies on assumptions. Two key assumptions are "crowd out"-- an estimate of the number of individuals who opt for the public plan because they believe it is cheaper than the private insurance for which they are eligible, or because their employer has dropped private coverage assuming the employee can sign up for the public plan instead; and "lower use rate"-- an estimate of the rate at which the uninsured use services compared to their use of services when insured. It is not feasible to unequivocally measure either of the assumptions. Last year, Medicaid advocated changing the crowd out assumption; this year, Medicaid is advocating a change in the use rate assumption. There are scant studies of uninsured use rates in peer reviewed literature, and without a unique

- more -

patient identifier to identify patient-level utilization patterns for all Maryland residents, it is impossible to measure the utilization patterns of the 2011 expansion population between 2010-2011.

Medicaid argues the 2011 expansion population is healthier than previous cohorts, did not have a pent-up demand while uninsured, and, therefore, more uncompensated care was actually averted. The trends in Figure 1 do not support this claim. The per-member-per-month cost Medicaid says it incurred increased 11 percent from 2010 to 2011. At the same time, both inpatient and outpatient hospital utilization declined more quickly than the all-payor utilization trends. Expansion population inpatient admissions per member declined by 22.5 percent and outpatient visits per member declined 11 percent. If the 2011 expansion population is healthier and using services less than expected, and Medicaid collected expansion funding based on a higher per-member-per-month cost, the expansion assessment was set too high and less uncompensated care was averted. A change in the uninsured's use rate is not supported.

Figure 1



Overestimates Fund Medicaid Operations Beyond Expansion

Actual averted uncompensated care has been grossly overestimated in 2010 and 2011; as a result, the additional expansion assessment funded Medicaid expenses beyond those incurred by the expansion population at hospitals. In 2010, expansion was estimated to avert $103.4 million in uncompensated care. When actual charges were tabulated, the actual averted uncompensated care was $74.1 million--a 40 percent overestimate. The crowd out assumption was then adjusted to reduce the overestimate, with the actual amount of averted uncompensated care determined to be $84.2 million--a 23 percent overestimate. In 2011, expansion-related averted uncompensated care was estimated at $135.1 million. Even with the revised crowd out assumption, expansion-related actual averted uncompensated care is $96 million--a 41 percent overestimate. HSCRC

staff is recommending changing the uninsured use rate assumption to 91 percent. Using the revised crowd out assumption and HSCRC's recommended use rate of 91 percent, actual averted uncompensated care in 2011 is $106.9 million--still a 26 percent overestimate.

The Medicaid program has benefited from overestimating expansion-related averted uncompensated care by being able to use the additional funding to support other Medicaid services in 2010–2012, and by utilizing these overestimates as the benchmark for the 1.25 percent fixed assessment, which was a seemingly reasonable estimate of expansion of costs written into law beginning with the fiscal year 2012 budget. Considering the trends in 2010 and 2011, it is likely that the 1.25 percent assessment Medicaid has collected in 2012 exceeds the hospital-related expansion costs by 25–40 percent. If actual averted uncompensated care were used to set the expansion assessment, the amount of the assessment as a percent of net revenue would have been 0.74 percent in 2010 and 0.96 percent in 2011. Actual assessments were 0.78 percent in 2010 and 1.07 percent in 2011. The surplus funds from the expansion assessments in 2010 and 2011 funded Medicaid budget shortfalls and are more accurately considered deficit funding. Likewise, the 2012 expansion assessment, to the extent that it was beyond the funding needed for expansion, could be considered deficit funding.

Despite these concerns, MHA recognizes the need for the HSCRC to move expeditiously on this reconciliation, so staff can address the more pressing concerns regarding the waiver. We remain deeply concerned regarding the continued overpayments to Medicaid, but will reluctantly support the recommendations presented by HSCRC staff. We also support this recommendation with the understanding that any remaining deficit assessment for FY 2013 (estimated to be $1.7 million) be netted against the amount due from Medicaid to hospitals for FY 2011.

MHA appreciates the opportunity to participate in the discussion of this issue and looks forward to working with the HSCRC on the future of the hospital specific reconciliation. If you have any questions, concerns or would like additional information, please contact me at 410-540-5087.

Sincerely,

Traci La Valle

Traci La Valle
Vice President, Financial Policy & Advocacy

cc: Commissioners, HSCRC

Final Report on Nurse Support Program I (NSP I) Activities for FY 2007 - FY 2012 and Recommendations for Program Renewal

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

July 11, 2012

These final recommendations have been approved at the Public Commission Meeting on July 11, 2012.

Purpose

This recommendation summarizes the activities of the Nurse Support Program I during the last 5 year cycle (FY 2007-FY 2012), and recommends renewal of the program for an additional 5 year cycle, with some program modifications.

Background

In 1986, the HSCRC initiated nurse education support through the collaborative efforts of hospitals, payers, and nursing representatives in response to a growing nursing shortage in Maryland. Originally, the Nurse Education Support Program (NESP) focused on supporting college and hospital-based training of Registered Nurses (RNs) and Licensed Practical Nurses (LPNs). Over the years, the NESP expanded to encourage new and innovative approaches to address the challenges and demands facing the nursing profession. HSCRC allocated approximately $7 million in hospital rates to thirty-seven hospitals that participated in the NESP from 1986 through 1995 when the program concluded.

As the economic situation in the US improved during the late 1990s-early 2000, another nursing shortage emerged. In 200l, the U.S. General Accounting Office conducted a study regarding the state of the nursing workforce in response to a congressional inquiry.[1] Results indicated that although national data were not adequate to describe the nature and extent of the potential nurse shortage, there was compelling evidence (declines in the RN unemployment rate and the RNs per capita) that suggests that the nursing shortage was a real phenomenon and that it would continue to grow. According to data from the National Sample Survey of Registered Nurses, there was a 2 percent decline nationally in the number of employed nurses per 100,000 people between 1996 and 2000. The study also listed multiple obstacles to increasing the supply of nurses including, an aging workforce, declines in younger nurses entering the field, a general dissatisfaction with the nursing environment (particularly staffing levels), concerns with quality of patient care, and lack of administrative support.

Although there was a slight (1.7 percent) increase in the number of employed RNs for the same time period in Maryland, the nursing workforce was experiencing similar dissatisfaction, according to a survey conducted by the Maryland Commission on the Crisis in Nursing in 2001.[2] In an effort to sustain and improve the number of bedside nurses in Maryland, the HSCRC initiated a new five–year, hospital-based, non-competitive grant program in 2000. The primary focus of Nurse Support Program I (NSP I) was increasing the number of bedside nurses in Maryland through retention and recruitment initiatives. Hospitals submitted proposals to the HSCRC for three- to five-year projects that ranged from nursing educational scholarships for their employees to high school outreach. A multi-stakeholder Evaluation Committee, comprised of nurse experts, reviewed the proposals and made recommendations to the Commission for funding. Funding was distributed through an increase in each hospital's rates equal to 0.1 percent of their regulated gross patient revenue from the prior year. Almost all Maryland acute care hospitals participated in NSP I from 2001-2006, receiving almost $36 million in rates.

[1] United States General Accounting Office, Nursing Workforce: Emerging Nurse Shortages Due to Multiple Factors (GAO-01-944, July 2001)
[2] Workplace Survey 2001. Maryland Commission on the Crisis in Nursing. Maryland Board of Nursing, Workplace Issues Subcommittee.

2007 Evaluation and Recommendation to the Commission

In 2005, HSCRC staff conducted an evaluation of the NSP I program, in part, because of difficulties in demonstrating program outcomes and accountability, unclear guidelines for eligible program activities, and a need to define the scope of the NSP I considering the initiation of the NSP II program in FY 2006. The Commission established the following NSP I evaluation goals:

- Clarify the categories of programs eligible for funding
- Fund projects deemed most valuable by nursing experts
- Simplify the application and reporting process, and
- Increase accountability through standardized program outcome and financial reporting

With the assistance of hospital industry, NSP I coordinators, nurse executives and educators, the Board of Nursing, and HSCRC leadership, HSCRC re-evaluated the NSP I program. HSCRC staff also contracted with a nurse researcher with nationally recognized expertise on the nursing shortage to provide consultation in program review and evaluation, and assistance with development of a standardized, objective reporting format. Upon completion of the evaluation, HSCRC staff recommended to the Commission the following modifications to the NSP I program:

1. Redefine categories of initiatives eligible for funding and establish categories that are ineligible for funding
2. Revise the Request for Applications process for grant funding to a simplified application process
3. Revise the review and evaluation process for initiative approvals and renewals
4. Ongoing review of the funding mechanism; and
5. Standardize quantitative annual reports to include uniform financial and annual data reporting requirements

The Commission approved program modifications and renewed funding for another five-year cycle from FY 2008 to FY 2012.

Implementation of the Modified NSP I Program

Application Process

In the spring of 2007, hospitals submitted proposals in response to an HSCRC-issued Request for Applications (RFAs) that incorporated areas recommended by nurse experts as being most valuable in improving nurse retention and the supply of bedside nurses. HSCRC staff encouraged hospitals to propose programs that included one or more of the following broad categories:

- **Educational Attainment**: This category includes all initiatives involving improved educational qualifications for nurses (RNs and LPNs) as well as initiatives to produce more nurses. Examples include: tuition, stipends, or release time for pursuit of additional education or qualification; software and hardware specifically dedicated for use in nursing education would be considered on an individual basis.

- **Nurse Retention and Recruitment:** This category applies to all initiatives involving retention of nurses. Examples include: mentoring, internships, residencies, and other support for new graduates and new hires, as well as, all initiatives involving recruitment including nurse shadowing programs, externships, and summer employment for prospective nursing students.
- **Improved Nurse Practice Environment:** This category applies to all initiatives to improve nurse practice environment including working on or achieving Magnet Status, joint governance, and other initiatives to improve nurse practice environment.

  For those healthcare organizations that did not plan to work toward achieving Magnet Status, projects related to the components of Magnet Status, or "Forces of Magnetism," such as implementation of professional standards of nursing practice, a nursing quality indicator program, or applied nursing research. Other examples include: programs to develop new approaches to staffing, scheduling, and allocation of patient care resources.
- **Other Creative Initiatives Proposals:** This category aims to increase the number of bedside nurses will be considered provided that the goals and objectives are clearly defined, evaluation metrics are identified, and budget requests fall within the defined NSP I parameters. These initiatives might include projects that require outside expertise that could be shared, such as the Project LINC (Ladders in Nursing Careers) and the Nurse Managers Leadership Institute, previously funded in part by NSP I.

An independent NSP I Evaluation Committee, comprised of representatives from HSCRC staff, hospital nursing leadership, payers, nursing recruiters, the Maryland Hospital Association, the Maryland Higher Education Commission, and human resources professionals reviewed the applications that met the minimum requirements outlined in the application form. The Evaluation Committee recommended 43 hospitals for funding for FY 2008, and the Commission approved the recommendation.

Revisions to the Annual Reports

HSCRC required hospitals to submit a standardized annual report and budget form at the end of each fiscal year. HSCRC staff expanded the annual report to include metrics that addressed the varied programs the hospitals proposed. HSCRC staff also developed a standardized budget form to assist in tracking how hospitals expended NSP I funds. HSCRC staff required hospitals to submit a proposed budget form at the beginning of the fiscal year. At the end of the fiscal year, hospitals reported their actual expenditures. HSCRC staff reduced the following year's budget request by the amount of the unspent funds in the prior year.

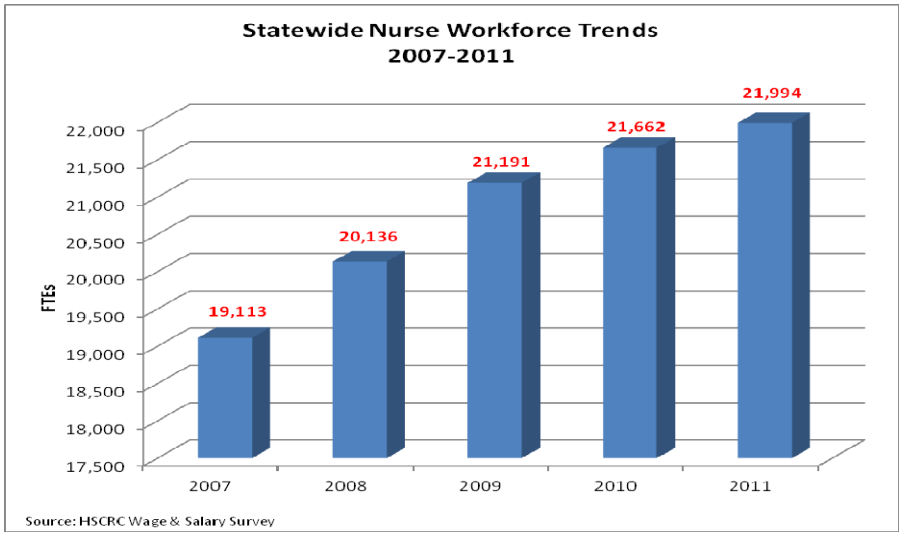
NSP I Achievements

The primary goal of the NSP I Program is to increase the number of bedside nurses in Maryland through retention and recruitment. Over the last 5 years, Maryland hospitals have met and exceeded this goal. The funding provided by NSP I has enabled hospitals to promote, nursing through enhanced educational opportunities, leadership development, research and shared governance. Hospitals indicate that these efforts have translated into higher satisfaction among Maryland nurses and better outcomes for patients.

Increased the Number of Bedside Nurses

In recent years, there has been a resurgence of nurses in the workforce. According to the HSCRC Wage and Salary Survey, Maryland hospitals increased the number of nurses by 15 percent between 2007 and 2011 (Chart 1). Eleven hospitals increased their nursing staff by more than 25 percent. The Commission requested HSCRC staff to research trends in the nursing workforce of neighboring states to determine how Maryland's nursing workforce trends compare regionally. Unfortunately, state-level workforce data for hospital-based nurses were not available for comparison. This lack of available, comparable, state-level data speaks to the need to "build an infrastructure for the collection and analysis of inter-professional healthcare workforce data" as described in the Institute of Medicine's Future of Nursing: Leading Change, Advancing Health report.[3]

Chart 1



There are several factors that may contribute to the increase in nursing workforce, including the state of the economy; nurses who would have otherwise retired are staying in their jobs or increasing their hours.[4] However, studies are predicting that this trend is temporary. The increasing demand for nurses to care for an aging nation, coupled with reduction in the workforce as nurses retire, will create an "unprecedented shortage of RN's in the United States."[5]

[3] Institute of Medicine of the National Academies. The Future of Nursing: Leading Change, Advancing Health. (2010)
[4] P. I. Buerhaus. Current and Future State of the US Nursing Workforce. *Journal of the American Medical Association*. 300:20 (2008).
[5] D.I. Auerbachm, P.I. Buerhaus & D.O. Staiger. Registered Nurse Supply Grows Faster Than Projected Amid Surge In New Entrants: Ages 23 -26. *Health Affairs*, 30, no.12 (2011):2286-2292; B.L.Cleary, A.B. McBride, M.L.McClure, & S.C. Reinhard. Expanding The Capacity Of Nursing . *Health Affairs*, 28, no.4 (2009):w634-w645

Hospitals attribute another reason for the increase in their nurse workforce to initiatives funded by the NSP I program. NSP I funding has enabled hospitals to develop programs aimed toward attracting and retaining new nursing graduates through rigorous residency and orientation programs, promoting nursing education for clinical and non-clinical staff, and providing extern and intern opportunities for nursing students who are subsequently hired as staff. For example, Johns Hopkins Hospital's Social and Professional Reality Integration for Nurse Graduates (SPRING) program focused on the retention of new graduate nurses in adult inpatient and critical care departments through a year-long internship. Through this program, Hopkins has been able to maintain an average retention rate of 88 percent among new graduates over the last 5 years. Franklin Square Hospital Center, through established partnerships with the weekend nursing program at Community College of Baltimore County (CCBC), increased the number of bedside RNs by offering tuition assistance to 30 non-clinical staff. With NSP I funding, Upper Chesapeake Medical Center (UCMC) sponsored an externship program where 90 percent of the students in the program have accepted RN positions at UCMC or at Harford Memorial Hospital. The externship program at Union Memorial Hospital (UMH) has produced 78 bedside nurses since FY2007; 59 of these nurses are currently employed at UMH.

Reduced Dependency on Agency Nurses

According to the HSCRC Wage and Salary survey, Maryland hospitals decreased their dependence on agency nurses by 68 percent, saving more than $98 million in agency costs between FY 2007 and FY 2011 (Chart 2). NSP I coordinators cite improved retention of existing nurses as the reason for the decreased usage of agency nurses.

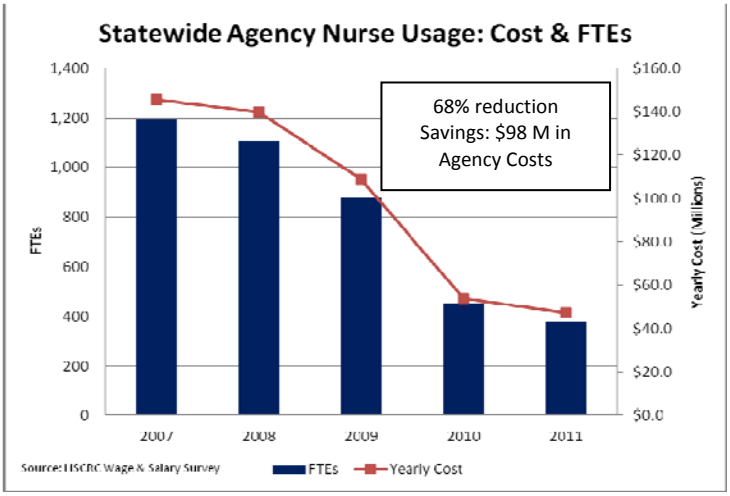


Chart 2

Increased the Number of Certified and Advanced Degree Nurses

A number of studies have shown a link between higher nursing education and better patient outcomes. One study showed compelling evidence that a 10 percent increase in the number of BSN degree nurses decreased the risk of patient death and failure to rescue by 5 percent.[6] In an effort to improve the level of education of their nursing staff, Maryland hospitals spent approximately $8.5 million on scholarships and tuition reimbursement for nursing education through the NSP I program between 2008 and 2011. Hospitals provide a majority of these funds (64 percent) for scholarships and tuition reimbursement for their nursing staff. Although, the number of hospitals reporting tuition assistance between FY 2008 and FY 2011 dropped from 25 hospitals to 19, investment in their staff's education more than doubled between FY 2008 and FY 2011, from $790,000 to $1.6 million respectively, peaking in FY2010 at $2.2 million. Maryland hospitals also invested close to $3 million in local nursing students through scholarships. In return, the students have service obligations at the hospital for a specific period of time ranging from 2 to 5 years. Between FY 2008 and FY2010, hospitals provided support to program participants pursuing the following degrees:

- 488 LPN or Associate degrees in Nursing
- 782 BSN degrees
- 95 MSN degrees

Maryland hospitals have also encouraged nursing staff to improve their competencies through professional certifications. Approximately 2,800 nurses completed certifications in various areas including, emergency room, pain management, wound care, medical-surgical and neonatal, through the NSP I initiatives between 2008 and 2011. St. Joseph Hospital used NSP I funds to improve the percentage of nurses with professional certifications. In FY 2011, the number of nurses with professional certifications at St. Joseph Hospital increased from 7 percent to 22 percent. Mercy has also seen a dramatic increase the number of certified nurses, from 22 in FY 2007 to 146 in FY 2011, a 564 percent increase.

Reduced Nurse Vacancy and Turnover Rates

Although a direct link cannot be made between the NSP I programs and vacancy or turnover rates, statewide data show significant reductions in vacancy rates for RNs and LPNs (26 percent and 57 percent, respectively) during this NSP I cycle (Chart 3). There also seems to be a similar downward trend for turnover rates (Chart 4). LPN turnover and vacancy rates have risen in the last 3 years, possibly because of the increased push for LPNs to become RNs as opportunities for LPNs in hospitals have declined.

[6] L. H. Aiken, S.P. Clarke, R.B. Cheung, D. M. Sloane, & J.H. Silber. Educational Levels of Hospital Nurses and Surgical Patient Mortality. Journal of the American Medical Association. 290:12 (2003). 1617-1623

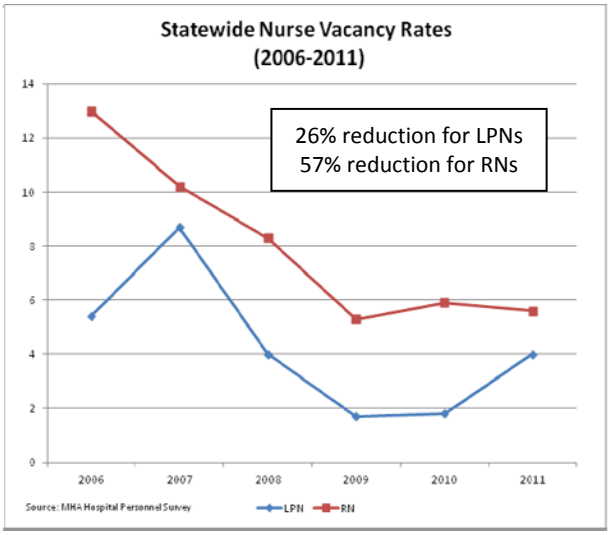


Chart 3

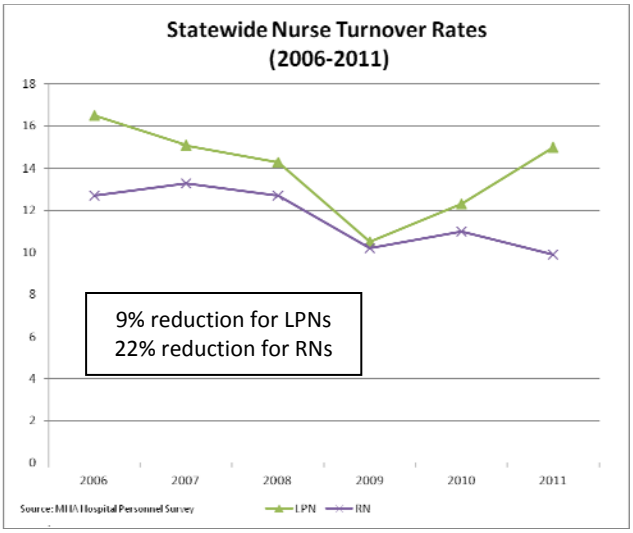


Chart 4

NSP I coordinators attribute the reduction in turnover and vacancy rates to improved nursing satisfaction. The funding provided by NSP I has enabled hospitals to promote nursing through enhanced educational opportunities, leadership development, research and joint governance. During the last 5 years, hospitals have established processes to encourage leadership development in a variety of areas. Some hospitals, like Bon Secours, have difficulty recruiting and retaining nurses because of their size or patient mix. Bon Secours invested its NSP I funds in developing an infrastructure for professional practice and engagement. The nursing leadership instituted councils that focus on three areas: professional development and improving the practice of nursing; recruitment, retention and recognition of nurses; and the lead partner's council. These councils provide nurses with a forum to communicate and collaborate with other departments. Through these efforts, Bon Secours have been able to reduce its voluntary turnover rate from 14 percent to 8 percent.

Recognized as Leaders in Nursing Excellence

The Magnet Recognition© program recognizes healthcare organizations for quality patient care, nursing excellence, and innovation in professional nursing practice. During the last 5 years, 6 hospitals have received Magnet© designation by the American Nurses Credentialing Center. These hospitals, and when they gained Magnet© status, are listed below:

- Franklin Square Hospital Center (2008)
- Sinai Hospital (2008)
- University of Maryland Medical Center (2009)
- Shore Health – Memorial Hospital of Easton (2009)
- Shore Health – Dorchester General Hospital (2009)
- Mercy Medical Center (2011)

With funding from the NSP I program, 11 more Maryland hospitals are on course to Magnet© status.

Hospital quality data collected by the HSCRC have shown a link between Magnet© hospitals and improved patient care, safety, and satisfaction. For FY2011, Maryland Magnet© hospitals had lower rates of most nursing-sensitive Maryland hospital acquired complications (MHACs) than non- Magnet© Maryland hospitals, for all measures except one, the difference was not significant.

Nursing Sensitive Hospital-Acquired Complications, FY 2011
Risk Adjusted Complication Rates per 1,000 admission
Source: 3M Potentially Preventable Complications (PPC) Grouper using HSCRC FY2011 Abstract Data

MHAC Measure	Magnet Hospitals	Non-Magnet Hospitals	Difference
PPC 5: Pneumonia and Other Lung Infections	5.00	5.59	-10.43%
PPC 6: Aspiration Pneumonia	2.34	2.76	-15.43%
PPC 22: Urinary Tract Infection	7.59	6.51	16.71%
PPC 28: In-Hospital Trauma and Fractures*	0.07	0.27	-66.93%
PPC 31: Decibutus Ulcer	1.17	1.55	-24.16%
PPC 54 Infections Due to Central Venous Catheters	0.58	0.36	61.87%

***Statistically Significant**

On the Hospital Care Quality Information from the Consumer Perspective (HCAHPS), for CY 2010, Maryland Magnet© hospitals tended to score higher on indicators of patient satisfaction than non- Magnet© hospitals, however, for all measures except one, the difference was not significant.

Patient Experience of Care Measures, CY 2010
Source: HCAHPS

HCAHPS Measure	Magnet Hospitals	Non-Magnet Hospitals	Difference
Communication About Medicines (Q16-Q17)*	61.8%	57.0%	4.81%
Communication With Nurses (Q1-Q3)	78.7%	76.0%	2.72%
Discharge Information (Q19-Q20)	85.3%	80.8%	4.49%
Responsiveness of Hospital Staff (Q4,Q11)	61.2%	56.8%	4.37%
Communication With Doctors (Q5-Q7)	79.7%	77.9%	1.77%
Pain Management (Q13-Q14)	68.8%	67.3%	1.56%
Cleanliness of Hospital Environment	64.8%	64.2%	0.66%

Patient Experience of Care Measures, CY 2010 Source: HCAHPS			
HCAHPS Measure	Magnet Hospitals	Non-Magnet Hospitals	Difference
Quietness of Hospital Environment	53.3%	53.8%	-0.47%
Willingness to Recommend this Hospital	71.0%	66.0%	5.03%
Overall Rating of this Hospital	69.7%	64.7%	4.99%
HCAHPS score in QBR for FY2012 Rates	56.8%	37.7%	19.14%
*Statistically Significant			

The Future of Nursing: IOM Recommendations

In 2010, the Institute of Medicine (IOM) published a groundbreaking report based on a two year initiative to respond to the need to assess and transform the nursing profession. The report laid out 8 recommendations to address the increasing demand for high quality and effective health care service. HSCRC Staff convened a workgroup with nursing leaders representing Sinai, Mt. Washington, Anne Arundel, and MedStar hospitals, to discuss how to incorporate four of the IOM recommendations into the scope of NSP I.

IOM Recommendation 3: Implement nurse residency programs. Maryland hospitals have already engaged in components of residency programs, including mentoring and extended orientations for new hires and graduates, and by encouraging evidenced based research and competency training for hard-to fill positions. The workgroup recommended standardizing the definition of residency programs and defining specific criteria for the components. The NSP I programs should also support hospitals that desire to pursue accreditation by the Commission on Collegiate Nursing Education (CCNE), an autonomous accreditation body that ensures the quality and integrity of baccalaureate, graduate, and residency programs in nursing.

IOM Recommendation 4: Increase the proportion of nurses with a baccalaureate degree to 80 percent by 2020. As reported above, Maryland hospitals are supporting nurses who are pursuing advanced degrees, but data are not consistently reported. The workgroup suggested that statewide targets be set for the number of nurses graduating with advanced degrees and that metrics be defined to track progress.

IOM Recommendation 6: Ensure that nurses engage in lifelong learning. Maryland hospitals are already sponsoring continuing education opportunities for their nursing staff. Examples of NSP I funded activities include: sending their nurses to national conferences, specialty training, and establishing simulation labs to improve the competency of their nursing staff. The NSP I program will continue to support these activities that will prepare Maryland's nursing workforce to provide "care for diverse populations across the lifespan."[7]

IOM Recommendation 7: Prepare and enable nurses to lead change to advance health. Data from the Wage and Salary survey show a slight increase in the number of nurse managers during this NSP I cycle. With an impending nurse shortage forecasted, and as the current nursing leaders

[7] Institute of Medicine of the National Academies. The Future of Nursing: Leading Change, Advancing Health. (2010)

retire, growing a new generation of nursing leaders is an important step in a hospitals succession planning. However, nurse management is not the only area in which staff nurses can be leaders. Hospitals currently support many avenues for leadership. These include, clinical ladders, nurse champions in specialty areas, such as wound care, mentors, preceptors and educators, as well as management training. The NSP I program will continue to support programs that provide opportunities for nurses to develop leadership skills.

Staff Recommendations: Moving Toward Nursing Excellence

In preparing for this recommendation, HSCRC staff convened two NSP I Coordinator meetings to obtain feedback about NSP I, particularly regarding modifications to the program that will enable hospitals and staff to clearly demonstrate the value of the program. Based on these discussions, HSCRC staff recommends renewing the NSP I program for an additional 5 year cycle, with the modifications described in the following recommendations.

Revise focus of NSP I Program

Evidence has shown that nursing excellence is linked to improved patient outcomes, low nursing turnover, and increased satisfaction among nursing staff. Incorporating the IOM recommendations into the scope of the NSP I program provides guidance to move all hospitals toward nursing excellence.

Recommendation 1: In an effort to raise the bar for Maryland nurses, the NSP I program should focus on three areas to achieve nursing excellence for all hospitals in Maryland:

- **Education and career advancement.** The NSP I program aim to increase the number of advance degree nurses, collect standardized metrics for educational attainment, define and standardize criteria for nursing residency programs, and define and collect data on leadership initiatives and succession planning.
- **Patient quality and satisfaction.** The NSP I program will utilize existing nursing sensitive metrics to demonstrate the link between improved nursing competency and better patient outcomes.
- **Advancing the practice of nursing.** The NSP I program will continue to support activities that advance the practice of nursing, such as staff driven evidenced-based research in nursing, attendance at symposiums and research conferences, as well as achieving or maintaining Magnet status.

Improve Application Process

Since the NSP I program is non-competitive, it is unnecessary to have a formal application process.

Recommendation 2: Instead of a formal application, hospitals will submit Letters of Commitment that describe their program and set goals using defined metrics to demonstrate program progress and outcomes. HSCRC staff, with input from hospital industry, will develop guidelines for the letters that outline reporting and compliance expectations. If hospitals need to revise their programs, there will be a process for submitting changes for review and approval.

Revise Annual Report and Budget Form

In an effort to move away from qualitative data, HSCRC developed a quantitative data collection tool that was capable of capturing outcomes from the varying programs implemented by hospitals. Unfortunately, this created a different problem; HSCRC staff received a large amount of data that still did not capture outcomes of the programs in a consistent way. There were a few metrics that could demonstrate outcome, such as vacancy and turnover rates; however, hospitals did not complete the data consistently, and the data could not be verified by other sources. In addition, tracking how NSP I funds were spent continued to be a challenging task. HSCRC review found several instances where hospitals had unfilled staff positions, but reported spending all the budgeted funds without indication of where the hospital redirected the funds budgeted for the unfilled positions. Hospitals did not report expenditures consistently, making it difficult for HSCRC staff to track and audit hospitals' use of NSP I funds. For FY 2011, hospitals spent 14 percent of their budgeted funds on "Other Expenses" that ranged from NCLEX Preparation courses to travel costs for staff.

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As stated above, monitoring the NSP I program has been challenging. Outside of the annual reports and budget submission, communication with HSCRC staff and with other NSP I coordinators has been minimal.

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> - Routine site visits at hospitals (began already in FY 2012)
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Final Report on Nurse Support Program I (NSP I) Activities for FY 2007 - FY 2012 and Recommendations for Program Renewal

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

July 11, 2012

These final recommendations have been approved at the Public Commission Meeting on July 11, 2012.

Purpose

This recommendation summarizes the activities of the Nurse Support Program I during the last 5 year cycle (FY 2007-FY 2012), and recommends renewal of the program for an additional 5 year cycle, with some program modifications.

Background

In 1986, the HSCRC initiated nurse education support through the collaborative efforts of hospitals, payers, and nursing representatives in response to a growing nursing shortage in Maryland. Originally, the Nurse Education Support Program (NESP) focused on supporting college and hospital-based training of Registered Nurses (RNs) and Licensed Practical Nurses (LPNs). Over the years, the NESP expanded to encourage new and innovative approaches to address the challenges and demands facing the nursing profession. HSCRC allocated approximately $7 million in hospital rates to thirty-seven hospitals that participated in the NESP from 1986 through 1995 when the program concluded.

As the economic situation in the US improved during the late 1990s-early 2000, another nursing shortage emerged. In 200l, the U.S. General Accounting Office conducted a study regarding the state of the nursing workforce in response to a congressional inquiry.[1] Results indicated that although national data were not adequate to describe the nature and extent of the potential nurse shortage, there was compelling evidence (declines in the RN unemployment rate and the RNs per capita) that suggests that the nursing shortage was a real phenomenon and that it would continue to grow. According to data from the National Sample Survey of Registered Nurses, there was a 2 percent decline nationally in the number of employed nurses per 100,000 people between 1996 and 2000. The study also listed multiple obstacles to increasing the supply of nurses including, an aging workforce, declines in younger nurses entering the field, a general dissatisfaction with the nursing environment (particularly staffing levels), concerns with quality of patient care, and lack of administrative support.

Although there was a slight (1.7 percent) increase in the number of employed RNs for the same time period in Maryland, the nursing workforce was experiencing similar dissatisfaction, according to a survey conducted by the Maryland Commission on the Crisis in Nursing in 2001.[2] In an effort to sustain and improve the number of bedside nurses in Maryland, the HSCRC initiated a new five–year, hospital-based, non-competitive grant program in 2000. The primary focus of Nurse Support Program I (NSP I) was increasing the number of bedside nurses in Maryland through retention and recruitment initiatives. Hospitals submitted proposals to the HSCRC for three- to five-year projects that ranged from nursing educational scholarships for their employees to high school outreach. A multi-stakeholder Evaluation Committee, comprised of nurse experts, reviewed the proposals and made recommendations to the Commission for funding. Funding was distributed through an increase in each hospital's rates equal to 0.1 percent of their regulated gross patient revenue from the prior year. Almost all Maryland acute care hospitals participated in NSP I from 2001-2006, receiving almost $36 million in rates.

[1] United States General Accounting Office, Nursing Workforce: Emerging Nurse Shortages Due to Multiple Factors (GAO-01-944, July 2001)
[2] Workplace Survey 2001. Maryland Commission on the Crisis in Nursing. Maryland Board of Nursing, Workplace Issues Subcommittee.

2007 Evaluation and Recommendation to the Commission

In 2005, HSCRC staff conducted an evaluation of the NSP I program, in part, because of difficulties in demonstrating program outcomes and accountability, unclear guidelines for eligible program activities, and a need to define the scope of the NSP I considering the initiation of the NSP II program in FY 2006. The Commission established the following NSP I evaluation goals:

- Clarify the categories of programs eligible for funding
- Fund projects deemed most valuable by nursing experts
- Simplify the application and reporting process, and
- Increase accountability through standardized program outcome and financial reporting

With the assistance of hospital industry, NSP I coordinators, nurse executives and educators, the Board of Nursing, and HSCRC leadership, HSCRC re-evaluated the NSP I program. HSCRC staff also contracted with a nurse researcher with nationally recognized expertise on the nursing shortage to provide consultation in program review and evaluation, and assistance with development of a standardized, objective reporting format. Upon completion of the evaluation, HSCRC staff recommended to the Commission the following modifications to the NSP I program:

1. Redefine categories of initiatives eligible for funding and establish categories that are ineligible for funding
2. Revise the Request for Applications process for grant funding to a simplified application process
3. Revise the review and evaluation process for initiative approvals and renewals
4. Ongoing review of the funding mechanism; and
5. Standardize quantitative annual reports to include uniform financial and annual data reporting requirements

The Commission approved program modifications and renewed funding for another five-year cycle from FY 2008 to FY 2012.

Implementation of the Modified NSP I Program

Application Process

In the spring of 2007, hospitals submitted proposals in response to an HSCRC-issued Request for Applications (RFAs) that incorporated areas recommended by nurse experts as being most valuable in improving nurse retention and the supply of bedside nurses. HSCRC staff encouraged hospitals to propose programs that included one or more of the following broad categories:

- **Educational Attainment**: This category includes all initiatives involving improved educational qualifications for nurses (RNs and LPNs) as well as initiatives to produce more nurses. Examples include: tuition, stipends, or release time for pursuit of additional education or qualification; software and hardware specifically dedicated for use in nursing education would be considered on an individual basis.

- **Nurse Retention and Recruitment:** This category applies to all initiatives involving retention of nurses. Examples include: mentoring, internships, residencies, and other support for new graduates and new hires, as well as, all initiatives involving recruitment including nurse shadowing programs, externships, and summer employment for prospective nursing students.
- **Improved Nurse Practice Environment:** This category applies to all initiatives to improve nurse practice environment including working on or achieving Magnet Status, joint governance, and other initiatives to improve nurse practice environment.

  For those healthcare organizations that did not plan to work toward achieving Magnet Status, projects related to the components of Magnet Status, or "Forces of Magnetism," such as implementation of professional standards of nursing practice, a nursing quality indicator program, or applied nursing research. Other examples include: programs to develop new approaches to staffing, scheduling, and allocation of patient care resources.
- **Other Creative Initiatives Proposals:** This category aims to increase the number of bedside nurses will be considered provided that the goals and objectives are clearly defined, evaluation metrics are identified, and budget requests fall within the defined NSP I parameters. These initiatives might include projects that require outside expertise that could be shared, such as the Project LINC (Ladders in Nursing Careers) and the Nurse Managers Leadership Institute, previously funded in part by NSP I.

An independent NSP I Evaluation Committee, comprised of representatives from HSCRC staff, hospital nursing leadership, payers, nursing recruiters, the Maryland Hospital Association, the Maryland Higher Education Commission, and human resources professionals reviewed the applications that met the minimum requirements outlined in the application form. The Evaluation Committee recommended 43 hospitals for funding for FY 2008, and the Commission approved the recommendation.

Revisions to the Annual Reports

HSCRC required hospitals to submit a standardized annual report and budget form at the end of each fiscal year. HSCRC staff expanded the annual report to include metrics that addressed the varied programs the hospitals proposed. HSCRC staff also developed a standardized budget form to assist in tracking how hospitals expended NSP I funds. HSCRC staff required hospitals to submit a proposed budget form at the beginning of the fiscal year. At the end of the fiscal year, hospitals reported their actual expenditures. HSCRC staff reduced the following year's budget request by the amount of the unspent funds in the prior year.

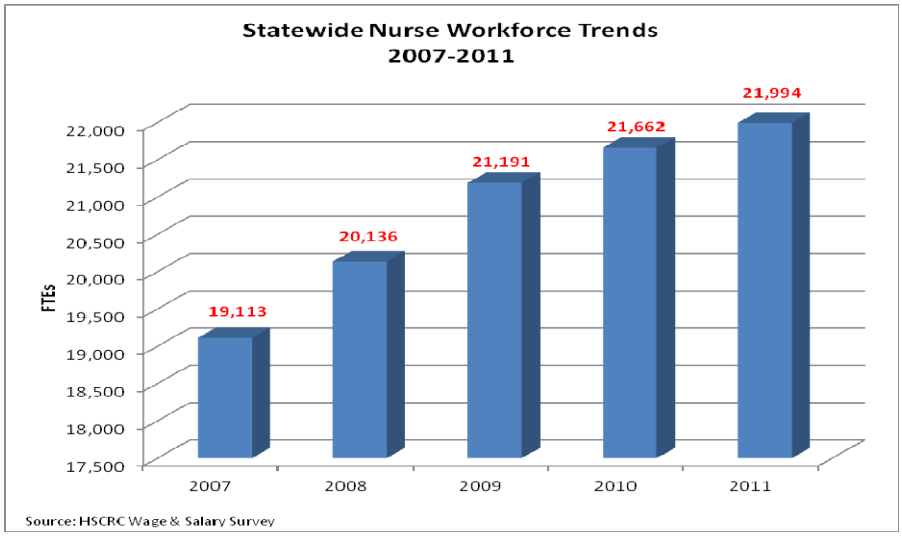
NSP I Achievements

The primary goal of the NSP I Program is to increase the number of bedside nurses in Maryland through retention and recruitment. Over the last 5 years, Maryland hospitals have met and exceeded this goal. The funding provided by NSP I has enabled hospitals to promote, nursing through enhanced educational opportunities, leadership development, research and shared governance. Hospitals indicate that these efforts have translated into higher satisfaction among Maryland nurses and better outcomes for patients.

Increased the Number of Bedside Nurses

In recent years, there has been a resurgence of nurses in the workforce. According to the HSCRC Wage and Salary Survey, Maryland hospitals increased the number of nurses by 15 percent between 2007 and 2011 (Chart 1). Eleven hospitals increased their nursing staff by more than 25 percent. The Commission requested HSCRC staff to research trends in the nursing workforce of neighboring states to determine how Maryland's nursing workforce trends compare regionally. Unfortunately, state-level workforce data for hospital-based nurses were not available for comparison. This lack of available, comparable, state-level data speaks to the need to "build an infrastructure for the collection and analysis of inter-professional healthcare workforce data" as described in the Institute of Medicine's Future of Nursing: Leading Change, Advancing Health report.[3]

Chart 1



There are several factors that may contribute to the increase in nursing workforce, including the state of the economy; nurses who would have otherwise retired are staying in their jobs or increasing their hours.[4] However, studies are predicting that this trend is temporary. The increasing demand for nurses to care for an aging nation, coupled with reduction in the workforce as nurses retire, will create an "unprecedented shortage of RN's in the United States."[5]

[3] Institute of Medicine of the National Academies. The Future of Nursing: Leading Change, Advancing Health. (2010)
[4] P. I. Buerhaus. Current and Future State of the US Nursing Workforce. *Journal of the American Medical Association*. 300:20 (2008).
[5] D.I. Auerbachm, P.I. Buerhaus & D.O. Staiger. Registered Nurse Supply Grows Faster Than Projected Amid Surge In New Entrants: Ages 23 -26. *Health Affairs*, 30, no.12 (2011):2286-2292; B.L.Cleary, A.B. McBride, M.L.McClure, & S.C. Reinhard. Expanding The Capacity Of Nursing . *Health Affairs*, 28, no.4 (2009):w634-w645

Hospitals attribute another reason for the increase in their nurse workforce to initiatives funded by the NSP I program. NSP I funding has enabled hospitals to develop programs aimed toward attracting and retaining new nursing graduates through rigorous residency and orientation programs, promoting nursing education for clinical and non-clinical staff, and providing extern and intern opportunities for nursing students who are subsequently hired as staff. For example, Johns Hopkins Hospital's Social and Professional Reality Integration for Nurse Graduates (SPRING) program focused on the retention of new graduate nurses in adult inpatient and critical care departments through a year-long internship. Through this program, Hopkins has been able to maintain an average retention rate of 88 percent among new graduates over the last 5 years. Franklin Square Hospital Center, through established partnerships with the weekend nursing program at Community College of Baltimore County (CCBC), increased the number of bedside RNs by offering tuition assistance to 30 non-clinical staff. With NSP I funding, Upper Chesapeake Medical Center (UCMC) sponsored an externship program where 90 percent of the students in the program have accepted RN positions at UCMC or at Harford Memorial Hospital. The externship program at Union Memorial Hospital (UMH) has produced 78 bedside nurses since FY2007; 59 of these nurses are currently employed at UMH.

Reduced Dependency on Agency Nurses

According to the HSCRC Wage and Salary survey, Maryland hospitals decreased their dependence on agency nurses by 68 percent, saving more than $98 million in agency costs between FY 2007 and FY 2011 (Chart 2). NSP I coordinators cite improved retention of existing nurses as the reason for the decreased usage of agency nurses.

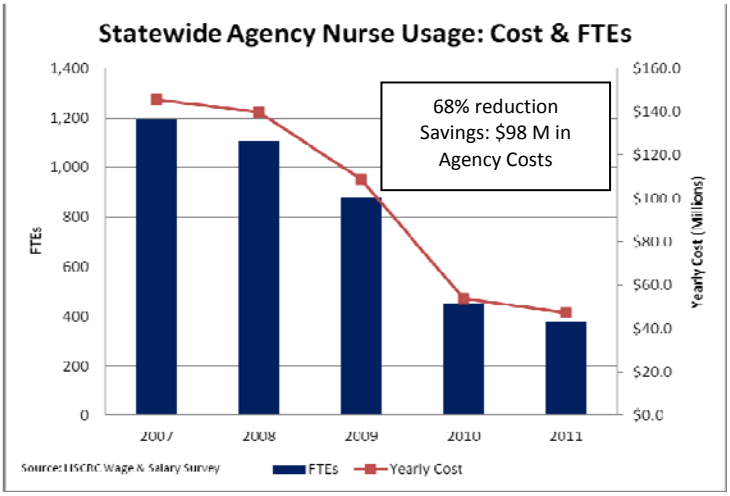


Chart 2

Increased the Number of Certified and Advanced Degree Nurses

A number of studies have shown a link between higher nursing education and better patient outcomes. One study showed compelling evidence that a 10 percent increase in the number of BSN degree nurses decreased the risk of patient death and failure to rescue by 5 percent.[6] In an effort to improve the level of education of their nursing staff, Maryland hospitals spent approximately $8.5 million on scholarships and tuition reimbursement for nursing education through the NSP I program between 2008 and 2011. Hospitals provide a majority of these funds (64 percent) for scholarships and tuition reimbursement for their nursing staff. Although, the number of hospitals reporting tuition assistance between FY 2008 and FY 2011 dropped from 25 hospitals to 19, investment in their staff's education more than doubled between FY 2008 and FY 2011, from $790,000 to $1.6 million respectively, peaking in FY2010 at $2.2 million. Maryland hospitals also invested close to $3 million in local nursing students through scholarships. In return, the students have service obligations at the hospital for a specific period of time ranging from 2 to 5 years. Between FY 2008 and FY2010, hospitals provided support to program participants pursuing the following degrees:

- 488 LPN or Associate degrees in Nursing
- 782 BSN degrees
- 95 MSN degrees

Maryland hospitals have also encouraged nursing staff to improve their competencies through professional certifications. Approximately 2,800 nurses completed certifications in various areas including, emergency room, pain management, wound care, medical-surgical and neonatal, through the NSP I initiatives between 2008 and 2011. St. Joseph Hospital used NSP I funds to improve the percentage of nurses with professional certifications. In FY 2011, the number of nurses with professional certifications at St. Joseph Hospital increased from 7 percent to 22 percent. Mercy has also seen a dramatic increase the number of certified nurses, from 22 in FY 2007 to 146 in FY 2011, a 564 percent increase.

Reduced Nurse Vacancy and Turnover Rates

Although a direct link cannot be made between the NSP I programs and vacancy or turnover rates, statewide data show significant reductions in vacancy rates for RNs and LPNs (26 percent and 57 percent, respectively) during this NSP I cycle (Chart 3). There also seems to be a similar downward trend for turnover rates (Chart 4). LPN turnover and vacancy rates have risen in the last 3 years, possibly because of the increased push for LPNs to become RNs as opportunities for LPNs in hospitals have declined.

[6] L. H. Aiken, S.P. Clarke, R.B. Cheung, D. M. Sloane, & J.H. Silber. Educational Levels of Hospital Nurses and Surgical Patient Mortality. Journal of the American Medical Association. 290:12 (2003). 1617-1623

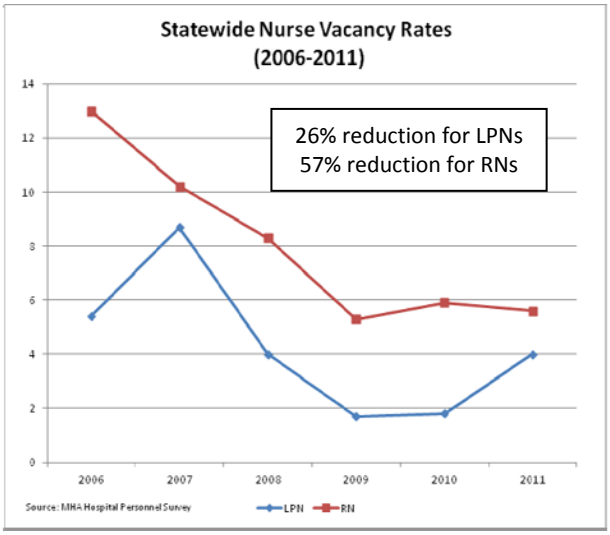


Chart 3

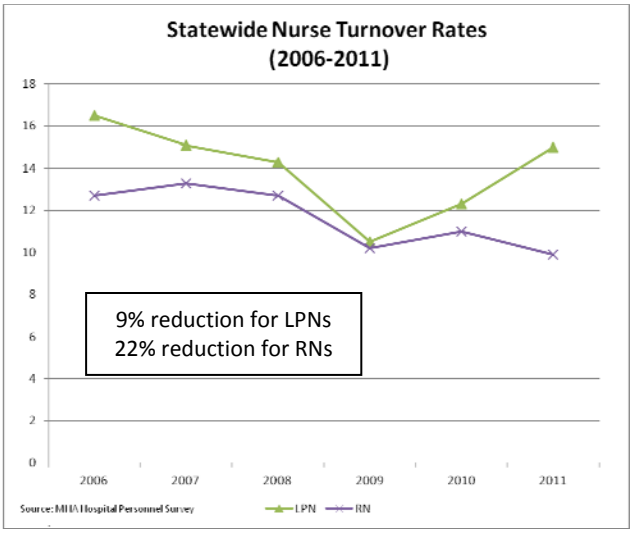


Chart 4

NSP I coordinators attribute the reduction in turnover and vacancy rates to improved nursing satisfaction. The funding provided by NSP I has enabled hospitals to promote nursing through enhanced educational opportunities, leadership development, research and joint governance. During the last 5 years, hospitals have established processes to encourage leadership development in a variety of areas. Some hospitals, like Bon Secours, have difficulty recruiting and retaining nurses because of their size or patient mix. Bon Secours invested its NSP I funds in developing an infrastructure for professional practice and engagement. The nursing leadership instituted councils that focus on three areas: professional development and improving the practice of nursing; recruitment, retention and recognition of nurses; and the lead partner's council. These councils provide nurses with a forum to communicate and collaborate with other departments. Through these efforts, Bon Secours have been able to reduce its voluntary turnover rate from 14 percent to 8 percent.

Recognized as Leaders in Nursing Excellence

The Magnet Recognition© program recognizes healthcare organizations for quality patient care, nursing excellence, and innovation in professional nursing practice. During the last 5 years, 6 hospitals have received Magnet© designation by the American Nurses Credentialing Center. These hospitals, and when they gained Magnet© status, are listed below:

- Franklin Square Hospital Center (2008)
- Sinai Hospital (2008)
- University of Maryland Medical Center (2009)
- Shore Health – Memorial Hospital of Easton (2009)
- Shore Health – Dorchester General Hospital (2009)
- Mercy Medical Center (2011)

With funding from the NSP I program, 11 more Maryland hospitals are on course to Magnet© status.

Hospital quality data collected by the HSCRC have shown a link between Magnet© hospitals and improved patient care, safety, and satisfaction. For FY2011, Maryland Magnet© hospitals had lower rates of most nursing-sensitive Maryland hospital acquired complications (MHACs) than non- Magnet© Maryland hospitals, for all measures except one, the difference was not significant.

Nursing Sensitive Hospital-Acquired Complications, FY 2011
Risk Adjusted Complication Rates per 1,000 admission
Source: 3M Potentially Preventable Complications (PPC) Grouper using HSCRC FY2011 Abstract Data

MHAC Measure	Magnet Hospitals	Non-Magnet Hospitals	Difference
PPC 5: Pneumonia and Other Lung Infections	5.00	5.59	-10.43%
PPC 6: Aspiration Pneumonia	2.34	2.76	-15.43%
PPC 22: Urinary Tract Infection	7.59	6.51	16.71%
PPC 28: In-Hospital Trauma and Fractures*	0.07	0.27	-66.93%
PPC 31: Decibutus Ulcer	1.17	1.55	-24.16%
PPC 54 Infections Due to Central Venous Catheters	0.58	0.36	61.87%

***Statistically Significant**

On the Hospital Care Quality Information from the Consumer Perspective (HCAHPS), for CY 2010, Maryland Magnet© hospitals tended to score higher on indicators of patient satisfaction than non- Magnet© hospitals, however, for all measures except one, the difference was not significant.

Patient Experience of Care Measures, CY 2010
Source: HCAHPS

HCAHPS Measure	Magnet Hospitals	Non-Magnet Hospitals	Difference
Communication About Medicines (Q16-Q17)*	61.8%	57.0%	4.81%
Communication With Nurses (Q1-Q3)	78.7%	76.0%	2.72%
Discharge Information (Q19-Q20)	85.3%	80.8%	4.49%
Responsiveness of Hospital Staff (Q4,Q11)	61.2%	56.8%	4.37%
Communication With Doctors (Q5-Q7)	79.7%	77.9%	1.77%
Pain Management (Q13-Q14)	68.8%	67.3%	1.56%
Cleanliness of Hospital Environment	64.8%	64.2%	0.66%

Patient Experience of Care Measures, CY 2010 Source: HCAHPS			
HCAHPS Measure	Magnet Hospitals	Non-Magnet Hospitals	Difference
Quietness of Hospital Environment	53.3%	53.8%	-0.47%
Willingness to Recommend this Hospital	71.0%	66.0%	5.03%
Overall Rating of this Hospital	69.7%	64.7%	4.99%
HCAHPS score in QBR for FY2012 Rates	56.8%	37.7%	19.14%
*Statistically Significant			

The Future of Nursing: IOM Recommendations

In 2010, the Institute of Medicine (IOM) published a groundbreaking report based on a two year initiative to respond to the need to assess and transform the nursing profession. The report laid out 8 recommendations to address the increasing demand for high quality and effective health care service. HSCRC Staff convened a workgroup with nursing leaders representing Sinai, Mt. Washington, Anne Arundel, and MedStar hospitals, to discuss how to incorporate four of the IOM recommendations into the scope of NSP I.

IOM Recommendation 3: Implement nurse residency programs. Maryland hospitals have already engaged in components of residency programs, including mentoring and extended orientations for new hires and graduates, and by encouraging evidenced based research and competency training for hard-to fill positions. The workgroup recommended standardizing the definition of residency programs and defining specific criteria for the components. The NSP I programs should also support hospitals that desire to pursue accreditation by the Commission on Collegiate Nursing Education (CCNE), an autonomous accreditation body that ensures the quality and integrity of baccalaureate, graduate, and residency programs in nursing.

IOM Recommendation 4: Increase the proportion of nurses with a baccalaureate degree to 80 percent by 2020. As reported above, Maryland hospitals are supporting nurses who are pursuing advanced degrees, but data are not consistently reported. The workgroup suggested that statewide targets be set for the number of nurses graduating with advanced degrees and that metrics be defined to track progress.

IOM Recommendation 6: Ensure that nurses engage in lifelong learning. Maryland hospitals are already sponsoring continuing education opportunities for their nursing staff. Examples of NSP I funded activities include: sending their nurses to national conferences, specialty training, and establishing simulation labs to improve the competency of their nursing staff. The NSP I program will continue to support these activities that will prepare Maryland's nursing workforce to provide "care for diverse populations across the lifespan."[7]

IOM Recommendation 7: Prepare and enable nurses to lead change to advance health. Data from the Wage and Salary survey show a slight increase in the number of nurse managers during this NSP I cycle. With an impending nurse shortage forecasted, and as the current nursing leaders

[7] Institute of Medicine of the National Academies. The Future of Nursing: Leading Change, Advancing Health. (2010)

retire, growing a new generation of nursing leaders is an important step in a hospitals succession planning. However, nurse management is not the only area in which staff nurses can be leaders. Hospitals currently support many avenues for leadership. These include, clinical ladders, nurse champions in specialty areas, such as wound care, mentors, preceptors and educators, as well as management training. The NSP I program will continue to support programs that provide opportunities for nurses to develop leadership skills.

Staff Recommendations: Moving Toward Nursing Excellence

In preparing for this recommendation, HSCRC staff convened two NSP I Coordinator meetings to obtain feedback about NSP I, particularly regarding modifications to the program that will enable hospitals and staff to clearly demonstrate the value of the program. Based on these discussions, HSCRC staff recommends renewing the NSP I program for an additional 5 year cycle, with the modifications described in the following recommendations.

Revise focus of NSP I Program

Evidence has shown that nursing excellence is linked to improved patient outcomes, low nursing turnover, and increased satisfaction among nursing staff. Incorporating the IOM recommendations into the scope of the NSP I program provides guidance to move all hospitals toward nursing excellence.

Recommendation 1: In an effort to raise the bar for Maryland nurses, the NSP I program should focus on three areas to achieve nursing excellence for all hospitals in Maryland:

- **Education and career advancement.** The NSP I program aim to increase the number of advance degree nurses, collect standardized metrics for educational attainment, define and standardize criteria for nursing residency programs, and define and collect data on leadership initiatives and succession planning.
- **Patient quality and satisfaction.** The NSP I program will utilize existing nursing sensitive metrics to demonstrate the link between improved nursing competency and better patient outcomes.
- **Advancing the practice of nursing.** The NSP I program will continue to support activities that advance the practice of nursing, such as staff driven evidenced-based research in nursing, attendance at symposiums and research conferences, as well as achieving or maintaining Magnet status.

Improve Application Process

Since the NSP I program is non-competitive, it is unnecessary to have a formal application process.

Recommendation 2: Instead of a formal application, hospitals will submit Letters of Commitment that describe their program and set goals using defined metrics to demonstrate program progress and outcomes. HSCRC staff, with input from hospital industry, will develop guidelines for the letters that outline reporting and compliance expectations. If hospitals need to revise their programs, there will be a process for submitting changes for review and approval.

Revise Annual Report and Budget Form

In an effort to move away from qualitative data, HSCRC developed a quantitative data collection tool that was capable of capturing outcomes from the varying programs implemented by hospitals. Unfortunately, this created a different problem; HSCRC staff received a large amount of data that still did not capture outcomes of the programs in a consistent way. There were a few metrics that could demonstrate outcome, such as vacancy and turnover rates; however, hospitals did not complete the data consistently, and the data could not be verified by other sources. In addition, tracking how NSP I funds were spent continued to be a challenging task. HSCRC review found several instances where hospitals had unfilled staff positions, but reported spending all the budgeted funds without indication of where the hospital redirected the funds budgeted for the unfilled positions. Hospitals did not report expenditures consistently, making it difficult for HSCRC staff to track and audit hospitals' use of NSP I funds. For FY 2011, hospitals spent 14 percent of their budgeted funds on "Other Expenses" that ranged from NCLEX Preparation courses to travel costs for staff.

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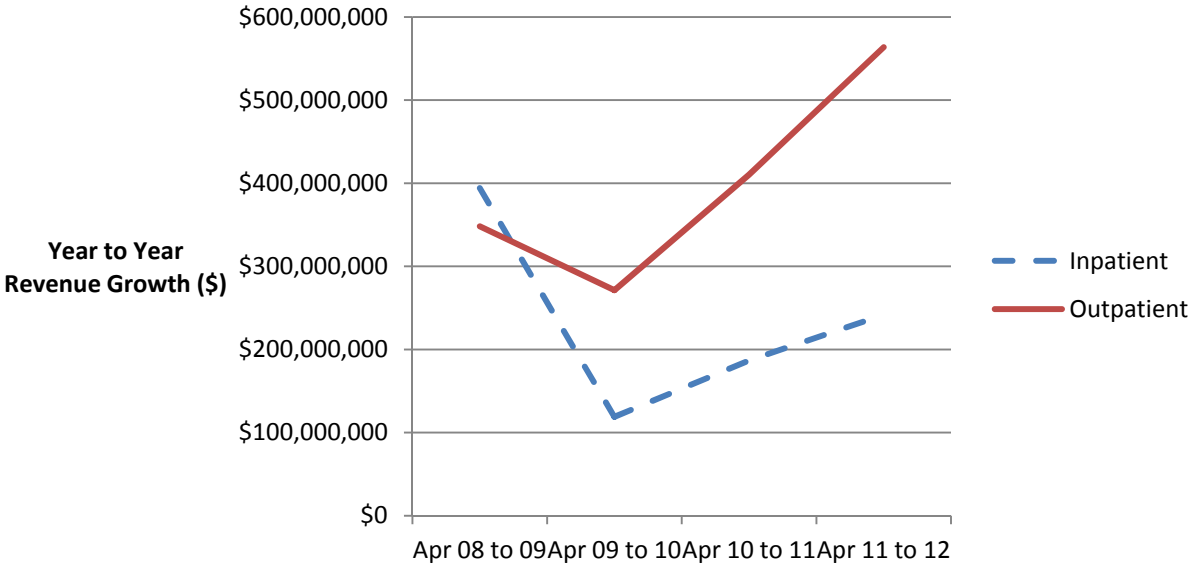
- Inpatient and outpatient hospital revenue is growing.
    - Year-over-year inpatient and outpatient revenue grew nearly a billion dollars.
- Outpatient revenue is growing faster than inpatient both in percentage growth and in total dollars (from Monitoring Maryland Performance)

Annual Revenue and Percent Growth, Inpatient and Outpatient Hospital				
	Inpatient		Outpatient	
	Annual Dollars	*Percent Annual Growth*	*Annual Dollars*	*Percent Annual Growth*
Apr 2008	$8,420,355,637	5.65%	$3,772,416,321	11.97%
Apr 2009	$8,814,567,729	4.68%	$4,120,535,128	9.23%
Apr 2010	$8,933,524,177	1.35%	$4,391,841,290	6.58%
Apr 2011	$9,120,294,728	2.09%	$4,802,129,427	9.34%
Apr 2012	$9,362,051,229	2.65%	$5,365,822,129	11.74%

Source: HSCRC, 2012. Monitoring Maryland Performance, financial data through April 2012.

Annual Revenue Growth, Inpatient and Outpatient Hospital



Source: HSCRC, 2012. Monitoring Maryland Performance, financial data through April 2012.

- Analysis does not indicate that outpatient growth in charges is driven by growth in specific rate centers.

Percentage of Overall Outpatient Charges, By Rate Center			
Rate Center	**Q1, Q2 FY 2010**	**Q1, Q2 FY 2011**	**Q1, Q2 FY 2012**
Drugs	11%	12%	13%
Clinic	9%	9%	9%
Emergency	16%	14%	14%
Laboratory	8%	8%	9%
Supplies	11%	11%	11%
Observation	0%	2%	3%
Operating Room	12%	12%	11%
Radiology	11%	11%	10%
Same Day Surgery	3%	4%	3%
Other Rate Centers	19%	17%	17%

Source: HSCRC, 2012. Case Mix Data, 6 Month Data.

- Staff conducted a point of entry analysis. This provided interesting insight on the distribution of charges among rate centers for visits.
    - Reinforced overall outpatient growth

Clinic Visits, Percent Change in Charges	
Rate Center	**Q1, Q2 FY 2010 to Q1, Q2 FY 2012**
Drugs (CDS)	49%
Clinic Services (CL)	25%
Laboratory Services (LAB)	24%
Medical Surgical Supplies (MSS)	15%
Operating Room Clinic Services (ORC)	15%
Radiology – Diagnostic (RAD)	30%
Radiology – Therapeutic (RAT)	5%

Source: HSCRC, 2012. Case Mix Data, 6 Month Data.

Clinic Visits, Charges as a Proportion of all Clinic Charges		
Rate Center	**Q1, Q2 FY 2010**	**Q1, Q2 FY 2012**
Drugs (CDS)	35%	40%
Clinic Services (CL)	44%	41%
Laboratory Services (LAB)	7%	7%
Medical Surgical Supplies (MSS)	1%	1%
Operating Room Clinic Services (ORC)	1%	1%
Radiology – Diagnostic (RAD)	2%	2%
Radiology – Therapeutic (RAT)	5%	4%

Source: HSCRC, 2012. Case Mix Data, 6 Month Data.

Same Day Surgery, Percent Change in Charges	
Rate Center	**Q1, Q2 FY 2010 to Q1, Q2 FY 2012**
Anesthesiology (ANS)	27%
Drugs (CDS)	35%
Laboratory Services (LAB)	40%
Medical Surgical Supplies (MSS)	27%
Operating Room (OR)	31%
Radiology – Diagnostic (RAD)	16%
Same Day Surgery (SDS)	37%

Source: HSCRC, 2012. Case Mix Data, 6 Month Data.

Same Day Surgery, Charges as a Proportion of all SDS Charges		
Rate Center	**Q1, Q2 FY 2010**	**Q1, Q2 FY 2012**
Anesthesiology (ANS)	4%	4%
Drugs (CDS)	2%	2%
Laboratory Services (LAB)	4%	5%
Medical Surgical Supplies (MSS)	30%	29%
Operating Room (OR)	42%	42%
Radiology – Diagnostic (RAD)	1%	1%
Same Day Surgery (SDS)	14%	14%

Source: HSCRC, 2012. Case Mix Data, 6 Month Data.

- Visits are up about 2 percent; however, there is a large difference between Total Patient Revenue (TPR) and non-TPR hospitals. For example:
    - o All hospital same day surgery visits are up 13 percent between Q1, Q2 FY 2010 and Q1, Q2 FY 2012.
    - o When we exclude TPR hospitals, same day surgery visits are up 17 percent in the same time period.

- Further efforts:
    - o Some additional analysis of hospital outpatient trends with TPR hospitals excluded
    - o Continue discussions of best constraint in a system with observed overall outpatient revenue and volume growth

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, 19-214, and 19-214.1; 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 July 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 November 26, 2012.

Statement of Purpose

The purpose of this amendment is to permit patients of other means-tested social services programs to be deemed presumptively eligible for free care.

Comparison of Federal Standards

There is no corresponding federal standard to this proposed action.

Estimate of Economic Impact

There is economic impact. See Estimate of Economic Impact Attached.

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 September 10, 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. – A-1 (Text unchanged).

A-2. Hospital Financial Assistance Responsibilities.

(1)-(2) (a)-(c) (i)-(v) (Text unchanged).

(vi) Other means-tested social services programs deemed eligible for hospital free care policies by the Department of Health and Mental Hygiene and the HSCRC.

(d)-(f) (Text unchanged).

B. – C. (Text unchanged).

JOHN M. COLMERS
Chairman
Health Services Cost Review Commission

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 FINAL ACTION

On July 11, 2012, the Health Services Cost Review Commission adopted amendments to Regulation **.26** under **COMAR 10.37.10 Rate Application and Approval Procedures.** This action, which was proposed for adoption in 39:10 Md. R. 665-666 (May 18, 2012), has been adopted as proposed.

Effective Date: **August 6, 2012**

JOHN M. COLMERS
Chairman
Health Services Cost Review Commission

Statement of Purpose

The purpose of this action is to repeal this chapter in its entirety since State and local laws already prohibit smoking indoors.

Comparison to Federal Standards

There is no corresponding federal standard to this proposed action.

Estimate of Economic Impact

The proposed action has no economic impact.

Economic Impact on Small Businesses

The proposed action has minimal or no economic impact on small businesses.

Impact on Individuals with Disabilities

The proposed action has no impact on individuals with disabilities.

Opportunity for Public Comment

Comments may be sent to Debbie Stone, Regulations Coordinator, Department of Labor, Licensing, and Regulation, Division of Labor and Industry, 1100 N. Eutaw Street, Room 606, Baltimore, Maryland 21201, or call 410-767-2225, or email to dstone@dllr.state.md.us, or fax to 410-767-2986. Comments will be accepted through June 18, 2012. A public hearing has not been scheduled.

J. RONALD DEJULIIS
Commissioner of Labor and Industry

Title 10
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Subtitle 14 CANCER CONTROL

10.14.02 Reimbursement for Breast and Cervical Cancer Diagnosis and Treatment

Authority: Health-General Article, §§2-102, 2-104, and 2-105, Annotated Code of Maryland

Notice of Proposed Action

[12-123-P]

The Secretary of Health and Mental Hygiene proposes to amend Regulation **.05** under **COMAR 10.14.02 Reimbursement for Breast and Cervical Cancer Diagnosis and Treatment**.

Statement of Purpose

The purpose of this action is to change the word "agreement" to "attestation" in order to reflect current terminology used by the Board of Nursing.

Comparison to Federal Standards

There is no corresponding federal standard to this proposed action.

Estimate of Economic Impact

The proposed action has no economic impact.

Economic Impact on Small Businesses

The proposed action has minimal or no economic impact on small businesses.

Impact on Individuals with Disabilities

The proposed action has no impact on individuals with disabilities.

Opportunity for Public Comment

Comments may be sent to Michele Phinney, Director, Office of Regulation and Policy Coordination, Department of Health and Mental Hygiene, 201 W. Preston Street, Baltimore, Maryland 21201, or call 410-767-6499 (TTY800-735-2258), or email to regs@dhmh.state.md.us, or fax to 410-767-6483. Comments will be accepted through June 18, 2012. A public hearing has not been scheduled.

.05 Nurse Practitioner Services.

A. To be considered a participating nurse practitioner in the Program, the provider shall:

(1) (text unchanged)

(2) Have a current written [agreement] *attestation* with a physician who is licensed to practice medicine in Maryland or a jurisdiction bordering Maryland, if required by that jurisdiction;

(3)—(6) (text unchanged)

B.—E. (text unchanged)

JOSHUA M. SHARFSTEIN, M.D.
Secretary of Health and Mental Hygiene

Subtitle 37 HEALTH SERVICES COST REVIEW COMMISSION

10.37.10 Rate Application and Approval Procedures

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

Notice of Proposed Action

[12-113-P]

The Health Services Cost Review Commission proposes to amend Regulation **.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 of this action is to notify hospital inpatients and outpatients of the potential for separate bills for hospital and physician services provided at the hospital.

Comparison to Federal Standards

There is no corresponding federal standard to this proposed action.

Estimate of Economic Impact

The proposed action has no economic impact.

Economic Impact on Small Businesses

The proposed action has minimal or no economic impact on small businesses.

Impact on Individuals with Disabilities

The proposed action has no impact on individuals with disabilities.

Opportunity for Public Comment

Comments may be sent to Diana Kemp, Administrator II, Health Services Cost Review Commission, 4160 Patterson Avenue, Baltimore, MD 21215, or call 410-764-2576, or email to dkemp@hscrc.state.md.us, or fax to 410-358-6217. Comments will be accepted through June 18, 2012. A public hearing has not been scheduled.

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

A. Hospital Information Sheet.

(1) Each hospital shall develop an information sheet that:

(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)

A-1. — C. (text unchanged)

JOHN M. COLMERS
Chairman
Health Services Cost Review Commission

Subtitle 45 MARYLAND COMMUNITY HEALTH RESOURCES COMMISSION

Notice of Proposed Action

[12-115-P]

The Maryland Community Health Resources Commission proposes to amend:

(1) Regulation **.02** under **COMAR 10.45.01 Purpose and Definitions**; and

(2) Regulation **.04** under **COMAR 10.45.05 Community Health Resources**.

This action was considered by the Maryland Community Health Resources Commission at a public meeting on April 12, 2012, notice of which was given by publication on the MCHRC website, pursuant to State Government Article, §10-506(c)(1), Annotated Code of Maryland.

Statement of Purpose

The purpose of this action is to add Developmental Disabilities Administration (DDA) licensees to the list of designated community health resources recognized under this subtitle.

Comparison to Federal Standards

There is no corresponding federal standard to this proposed action.

Estimate of Economic Impact

I. Summary of Economic Impact. The proposed action adds Developmental Disabilities Administration (DDA) licensees as a designated community health resource, making them eligible for grant funding from the Maryland Community Health Resources Commission (MCHRC). Organizations with a licensee from the Developmental Disabilities Administration that receive grant funds will be positively impacted by this proposed action.

II. Types of Economic Impact.	Revenue (R+/R-) Expenditure (E+/E-)	Magnitude
A. On issuing agency:		
DHMH (DDA/MCHRC)	(E+)	$6,000,000 GF/RF
B. On other State agencies:	NONE	
C. On local governments:	NONE	
	Benefit (+) Cost (-)	Magnitude
D. On regulated industries or trade groups:		
DDA licensees	(+)	$6,000,000
E. On other industries or trade groups:	NONE	
F. Direct and indirect effects on public:	NONE	

III. Assumptions. (Identified by Impact Letter and Number from Section II.)

A. and D. MCHRC's FY 2012 appropriation was amended in March 2012 to include $6,000,000 in Reimbursable Funds. The source of the reimbursable fund is General Funds in DDA -M0102 Community Services.

Economic Impact on Small Businesses

The proposed action has a meaningful economic impact on small business. An analysis of this economic impact follows.

The proposed action adds Developmental Disabilities Administration (DDA) licensees as a designated community health resource, making them eligible for grant funding from the Maryland Community Health Resources Commission (MCHRC). Organizations with a licensee from the Developmental Disabilities Administration that are small businesses that receive grant funds will be positively impacted by this proposed action.

Impact on Individuals with Disabilities

The proposed action has an impact on individuals with disabilities as follows:

The proposed action adds Developmental Disabilities Administration (DDA) licensees as a designated community health resource, making them eligible for grant funding from the Maryland Community Health Resources Commission (MCHRC). DDA licensee organizations serve individuals with developmental disabilities, who would likely benefit from grant funding awarded by the MCHRC.

Opportunity for Public Comment

Comments may be sent to Mark Luckner, Executive Director, Maryland Community Health Resources Commission, 45 Calvert Street, Room 336, Annapolis, Maryland 21401, or call (410) 260-6290 , or email to LucknerM@dhmh.state.md.us, or fax to (410) 626-0304. Comments will be accepted through June 18, 2012, 4:30 p.m. A public hearing has not been scheduled.

10.45.01 Purpose and Definitions

Authority: Health-General Article, §§19-2107, 19-2109, and 19-2201, Annotated Code of Maryland

.02 Definitions.

A. (text unchanged)

B. Terms Defined.

(1)—(8) (text unchanged)

(9) "Developmental Disabilities Administration (DDA) licensee" has the meaning stated in COMAR 10.22.01.01B(36).

[(9)] *(10)*—[(31)] *(32)* (text unchanged)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

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Chairman

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Vice-Chairman

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Hospital Rate Setting

Mary Beth Pohl
Deputy Director
Research and Methodology

TO: Commissioners

FROM: Legal Department

DATE: July 5, 2012

RE: Hearing and Meeting Schedule

Public Session:

August 1, 2012 The August 1, 2012 Commission Meeting is cancelled.

September 5, 2012 Time to be Determined, 4160 Patterson Avenue, HSCRC Conference Room

Please note, Commissioner packets will be available in the Commission's office at 10:00 a.m.

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

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