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Department of Health and Mental Hygiene



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**Health Services Cost Review Commission**

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**514th MEETING OF THE HEALTH SERVICES COST REVIEW COMMISSION  
December 10, 2014**

**EXECUTIVE SESSION**

**Noon**

**(The Commission will begin in public session at noon for the purpose of, upon motion and approval, adjourning into closed session. The open session will resume at 1PM.)**

- 1. Organizing Staff and Role of Commission regarding Certificate of Need Process – Authority State Government Article 10-503(a), and 10-508(a)(7)**
- 2. Status of Medicare Data Submission and Reconciliation – Authority State Government Article 10-503(a)**
- 3. Reviewing Commission Internal Process for Considering Legislation - Authority State Government Article 10-503(a)**

**PUBLIC SESSION OF THE  
HEALTH SERVICES COST REVIEW COMMISSION**

**1:00 p.m.**

- 1. Review of the Minutes from the Executive Session and Public Meeting on November 12, 2014**
- 2. Executive Director's Report + MHA Midyear Update Request**
- 3. New Model Monitoring**
- 4. Docket Status – Cases Closed**
  - 2257A – MedStar Health
  - 2269A – Johns Hopkins Health System
  - 2270A – St. Agnes Health, Maryland General Hospital, Meritus Health, Western Maryland Health System, and Holy Cross Health
  - 2274A – Johns Hopkins Health System
  - 2275A – Johns Hopkins Health System
  - 2276A – Johns Hopkins Health System
  - 2277A – University of Maryland Medical Center
- 5. Docket Status – Cases Open**
  - 2265A – Holy Cross Hospital
  - 2278A – Johns Hopkins Health System - *approved*
  - 2279A – MedStar Health - *approved*
  - 2280A - Johns Hopkins Health System - *approved*
  - 2281A – Riverside Health of Maryland - *approved*
- 6. Draft Recommendation for Modifications to the MHAC program for FY 2017**

- 7. Draft Recommendation for Modifications to the Readmission Reduction Incentive Program for FY 2017**
- 8. Draft Recommendations for Total Amount at Risk for Quality Programs for FY 2017**
- 9. Draft Report and Recommendation on the NSPII Program + Slides**
- 10. Draft Report on Medicaid Savings resulting from the All-Payer Model + Slides + Letter**
- 11. Final Recommendation on Modifying Medicaid Current Financing Calculation for CY 2015 - *approved***
- 12. Hearing and Meeting Schedule**

**Executive Session Minutes  
Of the  
Health Services Cost Review Commission**

**November 12, 2014**

Upon motion made, Chairman Colmers called the Executive Session to order at 12:17 p.m.

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

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

In attendance representing staff were Donna Kinzer, David Romans, Steve Ports, Ellen Englert, and Dennis Phelps.

Also attending were Leslie Schulman and Stan Lustman, Commission counsel, Jack Meyer, Ph.D., Facilitator, and Rob Cohen, consultant.

**Item One**

The Commission briefly discussed the Advisory Council meeting held today.

**Item Two**

David Romans, Principal Director of Payment Reform and Innovation, presented and Donna Kinzer, Executive Director, and the Commission discussed the analyses of HSCRC and Medicare experience data.

**Item Three**

The Commission discussed administrative and personnel issues.

**Item Four**

Dr. Meyer updated the Commission on the future activities of the Care Coordination work group.

**Item Five**

The Commission discussed additional personnel issues.

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

**MINUTES OF THE**  
**513th MEETING OF THE**  
**HEALTH SERVICES COST REVIEW COMMISSION**

**NOVEMBER 12, 2014**

Chairman John Colmers called the meeting to order at 1:08 p.m. Commissioners George H. Bone, M.D., Stephen F. Jencks, M.D., MPH, Jack C. Keane, Bernadette C. Loftus, M.D., Tom Mullen and Herbert S. Wong Ph.D. were in attendance.

**REPORT OF THE NOVEMBER 12, 2014 EXECUTIVE SESSION**

Dennis Phelps, Associate Director-Audit & Compliance, summarized the minutes of the November 12, 2014 Executive Session.

**ITEM I**  
**REVIEW OF THE MINUTES FROM OCTOBER 15, 2014 EXECUTIVE SESSION AND**  
**PUBLIC MEETING**

The Commission voted unanimously to approve the minutes of the October 15, 2014 Executive Session and the Public Meeting.

**GLOBAL BUDGET REVENUE FY 2015 UPDATE**

Mr. Jerry Schmith, Deputy Director Hospital Rate Setting, presented an update on the adjustments that will be incorporated in calculating the FY 2015 Global Budget Revenue (See Adjustments to Global Budget Revenue FDY 2015” on the HSCRC website).

**ITEM II**  
**NEW MODEL MONITORING**

Mr. David Romans, Director Payment Reform and Innovation, stated that Monitoring Maryland Performance (MMP) for the new All-Payer Model for the month of September will focus on fiscal year (July 1 through June 30) as well as calendar year results.

Mr. Romans reported that for the three months ended September 30, 2014, All-Payer total gross revenue increased by 3.95% over the same period in FY 2014. All-Payer total gross revenue for Maryland residents increased by 4.58%; this translates to a per capita growth of 3.87%. All-Payer gross revenue for non-Maryland residents decreased by 1.92%.

Mr. Romans reported that for the nine months of the calendar year ended September 30, 2014, All-Payer total gross revenue increased by 2.40% over the same period in FY 2013. All-Payer total gross revenue for Maryland residents increased by 2.70%; this translates to a per capita

growth of 2.01%. All-Payer gross revenue for non-Maryland residents decreased by .56%.

Mr. Romans reported that for the three months ended September 30, 2014, Medicare Fee-For-Service gross revenue increased by 3.72% over the same period in FY 2013. Medicare Fee-For-Service for Maryland residents increased by 4.38%; this translates to a per capita growth increase of 1.13%. Maryland Fee-For-Service gross revenue for non-residents decreased by 3.10%.

Mr. Romans reported that for the nine months of the calendar year ended September 30, 2014, Medicare Fee-For-Service gross revenue increased by 2.37%. Medicare Fee-For-Service for Maryland residents increased by 2.50%; this translates to a per capita growth decrease of .77%. Maryland Fee-For-Service gross revenue for non-residents increased by .93%.

According to Mr. Romans, for the three months of the calendar year ended September 30, 2014, unaudited average operating profit for acute hospitals was 2.90%. The median hospital profit was 4.02%, with a distribution of 1.43% in the 25<sup>th</sup> percentile and 6.94% in the 75<sup>th</sup> percentile.

Mr. Romans noted the underlying reason for the increase in the fiscal year to date revenue was due to an increase in outpatient volumes. Some of the increase in September revenues was due to outpatient surgery. Mr. Romans also noted that global budget spending has increased through the first three months of FY2014 when compared to the same time in FY2013.

Ms. Donna Kinzer, Executive Director, stated that staff has been working on development of product lines reporting for inpatient and outpatient cases. Also staff will focus on providing increased information to the Commission on volume trends for the January meeting.

Dr. Alyson Schuster, Associate Director Data & Research, presented a quality report update on the Maryland Hospital Acquired Conditions program based upon Potentially Preventable Complications (PPCs) data and discharges through September 2014 and readmission data on discharges through August 2014.

#### Potentially Preventable Complications

- The All-Payer risk adjusted PPC rate was 1.00 for September 2014 YTD. This is a decrease of 22.04% from the September 2013 YTD risk adjusted PPC rate.
- The Medicare Fee for Service risk adjusted PPC rate was 1.11 for September 2014 YTD. This is a decrease of 26.09% from the August 2013 risk adjusted PPC rate.
- These preliminary PPC results indicate that hospitals are on track for achieving the annual 6.89% PPC reduction required by CMMI to avoid corrective action.

#### Readmissions

- The All-Payer risk adjusted readmission rate was 12.05% August 2014 YTD. This is a decrease of 3.37% from the August 2013 risk adjusted readmission rate.
- The Medicare Fee for Service risk adjusted readmission rate was 13.04% for August 2014 YTD. This is a decrease of 1.16% from the August 2013 risk adjusted readmission.

- Based on the New-Payer model, hospitals must reduce Maryland's readmission rate to or below the national Medicare readmission rate by 2018. The Readmission Reduction incentive program has set goals for hospitals to reduce their adjusted readmission rate by 6.76% during CY 2014 compared to CY 2013. Currently, only 14 out of 46 hospitals have reduced their risk adjusted rate by more than 6.76%.

### **ITEM III** **EXECUTIVE DIRECTOR'S REPORT**

Ms. Kinzer stated that staff continued to monitor trends in uncompensated care. Staff has been evaluating changes in payer mix in the monthly case mix data. These data show a reduction in self pay and charity cases and a corresponding increase in Medicaid beyond the levels used to calculate the uncompensated care reduction. Staff will be obtaining quarterly submissions of write offs for hospitals starting in late November. These data will be helpful in understanding the continuing sources of uncompensated care.

Ms. Kinzer noted that the federal government reduced Medicare hospital rate increases on October 1, 2014 to reflect its estimate of the impact of Affordable Care Act on reducing the number of uninsured. This was applied through a reduction in the Disproportionate Share Hospital payment levels. Staff is working with CMS and Med Pac to gain a better understanding of how this will affect Medicare payment levels.

Ms. Kinzer stated for the month of December, staff expects to continue to focus on the market share calculations and to finalize updates to quality programs. Staff will increase its focus on analysis of uncompensated care and reporting volume changes. In addition, staff will develop a timeline for 2016 updates.

Ms. Kinzer noted that the care coordination workgroup first meeting will be on November 17<sup>th</sup> and will continue through February. Health Management Associates (HMA) will be providing consulting assistance to help the group.

Ms. Kinzer noted that provider alignment efforts will resume this month, with the assistance of HMA and other consulting resources.

Ms. Kinzer noted that Chairman Colmers has begun working with faculty of Johns Hopkins University and University of Maryland to develop a work plan that will focus on bringing together a work group to evaluate changes in training of residents to support the new All Payer Model. When the work is formalized, staff will arrange for a presentation to the Commission on these activities.

Ms. Kinzer noted that consumer groups are beginning new activities relative to informing and engaging consumers around the new All-Payer Model. One effort, led by Vincent DeMarco, will focus on recommending communications and community outreach. The second effort, led by Leni Preston, will focus on recommending approaches for consumer engagement.

Last month, the Maryland Health Care Commission (MHCC) presented its plans for the all payer database. Staff will ask MHCC to provide additional updates relative to plans for capital and certificate of needs programs as well as medical home initiatives.

**ITEM IV**  
**DOCKET STATUS CASES CLOSED**

2264N- Bowie Emergency Facility  
2266A- Johns Hopkins Health System  
2267A- University of Maryland Medical System  
2268A- University of Maryland Medical System  
2269A- Johns Hopkins Health System  
2271A- Johns Hopkins Health System  
2272A- Johns Hopkins Health System  
2273A- Johns Hopkins Health System

**ITEM V**  
**DOCKET STATUS CASES OPEN**

**2257A- MedStar Health**

Mr. Steve Ports, Principal Deputy Director Policy and Operations, summarized Staff's final recommendation on the application filed by MedStar Health System (the "System") on behalf of Franklin Square Hospital, Good Samaritan Hospital, Harbor Hospital and Union Memorial Hospital (the "Hospitals"). The System seeks renewal for the continued participation of MedStar Family Choice (MFC) in the Medicaid Health Choice Program. MFC is the entity that assumes risk under this contract. The Hospitals requested renewal of this contract for one year beginning in January 1, 2015.

Staff recommended:

- Approval of the alternative rate application for one-year period beginning January 1, 2015.
- That MFC report to the Commission staff (on or before the September 2015 meeting of the Commission) on the actual CY 2014 experience, preliminary CY 2015 financial performance (adjusted for seasonality) of the MCO, as well as projections for CY 2016; and
- That this approval be contingent upon the execution of the standard Memorandum of Understanding.

The Commission voted unanimously to approve staff's recommendation.

### **2269A- Johns Hopkins Health System**

Mr. Ports summarized staff's final recommendation for the application filed by Johns Hopkins Health System (the "System") on behalf of Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, Howard County General Hospital, and Suburban Hospital (the "Hospitals"). The System is seeking approval for continued participation of Priority Partners, Inc. in the Medicaid Health Choice Program. Priority Partners, Inc. is the entity that assumes risk under the contract. The Hospitals are requesting to renew the contract for one year beginning on January 1, 2015.

Staff recommended:

- Approval of the alternative rate application for one-year period beginning January 1, 2015.
- That Priority Partners Inc. report to the Commission staff (on or before the September 2015 meeting of the Commission) on the actual CY 2014 experience, preliminary CY 2015 financial performance (adjusted for seasonality) of the MCO, as well as projections for CY 2016; and
- That this approval be contingent upon the execution of the standard Memorandum of Understanding.

The Commission voted unanimously to approve staff's recommendation. Chairman Colmers recused himself from the discussion and vote.

### **2270A- St. Agnes Health, Maryland General Hospital, Meritus Health, Western Maryland Health System and Holy Cross Health**

Mr. Ports summarized staff's final recommendation for the applications of Maryland General Hospital, Saint Agnes Health System, Western Maryland Health System, and Meritus Health (the "Hospitals"). The Hospitals are requesting continued participation of Maryland Physician Care ("MPC") in the Medicaid Health Choice Program. MPC is the entity that assumes risk under this contract. The Hospitals requested renewal of this contract beginning January 1, 2015.

Staff recommended

- Approval of the alternative rate application for one-year period beginning January 1, 2015.
- That MPC report to the Commission staff (on or before the September 2015 meeting of the Commission) on the actual CY 2014 experience, preliminary CY 2015 financial performance (adjusted for seasonality) of the MCO, as well as projections for CY 2016; and
- That this approval be contingent upon the execution of the standard Memorandum of Understanding

The Commission voted unanimously to approve staff's recommendation.



### **2274A-Johns Hopkins Health System**

Johns Hopkins Health System (the “System”), on behalf its member hospitals Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center and Howard County General Hospital (the “Hospitals”), filed an application on October 15, 2014 requesting continued participation in a global rate arrangement for solid organ and bone marrow transplant services with Preferred Health Care LLC. beginning December 1, 2014.

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 one year beginning December 1, 2014, and that the approval be contingent upon the execution of the standard Memorandum of Understanding.

The Commission voted unanimously to approve staff’s recommendation. Chairman Colmers recused himself from the discussion and vote.

### **2275A-Johns Hopkins Health System**

Johns Hopkins Health System, on behalf its member hospitals Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center and Howard County General Hospital (the “Hospitals”), filed application on August 17, 2014 requesting continued participation in a global rate arrangement for cardiovascular procedures, kidney and bone marrow transplant services with the Canadian Medical Network beginning December 1, 2014.

Staff recommends that the Commission approve the Hospitals’ application for an alternative method of rate determination for cardiovascular procedures and kidney and bone marrow transplant services for one year beginning December 1, 2014, and that the approval be contingent upon the execution of the standard Memorandum of Understanding.

The Commission voted unanimously to approve staff’s recommendation. Chairman Colmers recused himself from the discussion and vote.

### **2276A-Johns Hopkins Health System**

Johns Hopkins Health System, on behalf its member hospitals Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center and Howard County General Hospital (the “Hospitals”), filed an application on October 17, 2014 requesting continued participation in a capitation arrangement serving persons insured with Tricare. The arrangement involves the Johns Hopkins Medical Services Corporation and Johns Hopkins Healthcare as providers for Tricare patients. The Hospitals have requested that approval be for one year beginning on January 1, 2015.

Staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for one year beginning January 1, 2015, and that the approval be contingent upon the execution of the standard Memorandum of Understanding.

The Commission voted unanimously to approve staff's recommendation. Chairman Colmers recused himself from the discussion and vote.

### **2277A-University of Maryland Medical Center**

The University of Maryland Medical Center (the "Hospital") filed a renewal application with the HSCRC on October 17, 2014 seeking approval to participate in a new global rate arrangement with Humana for solid organ and blood and bone marrow transplant services for a one year period beginning November 1, 2014.

The staff recommended that the Commission waive the requirement that alternative application be filed 30 days before the proposed effective date. The staff also recommended that the Commission approve the Hospital's application for a one year period commencing November 1, 2014, and that the approval be contingent upon the execution of the standard Memorandum of Understanding.

The Commission voted unanimously to approve staff's recommendation.

### **ITEM VI**

#### **GLOBAL BUDGET REVENUE INFRASTRUCTURE INVESTMENT REPORTING**

Dr. Schuster presented an update on Global Budget Revenue (GBR) Infrastructure Investment reporting (See "GBR Infrastructure Investment Reporting" on the HSCRC website).

Dr. Schuster noted that this report summarizes hospital investments to improve population health. This report is required by hospital GBR contracts so staff can understand, quantify and analyze the investments that hospitals are making with respect to additional GBR infrastructure funds included in rates.

Dr. Schuster stated that the FY2014 and FY2015 reports will be submitted together and are due ninety days after the end of FY2015. Hospitals may submit interim reports to the HSCRC for feedback, which will be required for any hospital seeking increases in its global budget or relief from rate corridors. Dr. Schuster identified three types of investments to be reported:

- Patient Centered Investments
  - Case Management, care coordination, transitional care and chronic disease management
  - Medication and care compliance initiatives
  - Patient education

- Provider/Care Team Investments
  - Support to encourage evidence-based medicine.
  - Provider pay for performance or shared savings model infrastructure.
  - Seed funding to recruit and retain primary care or other providers to fill critical gaps in community health infrastructure.
- Health Information Technology Investments
  - Health information technology expenses to support patient centered and provider/care team interventions.

**ITEM VII**  
**REPORT ON THE FY 2013 FINANCIAL DISCLOSURE REPORT**

Mr. Dennis Phelps, Associate Director-Audit & Compliance, summarized the annual disclosure of financial and statistical data for Maryland hospitals for FY 2013 (See “Disclosure of Hospital Financial and Statistical Data” on the HSCRC website). Major highlights of the report were:

- Patients in Maryland hospitals paid 1.8% more in FY 2013 than in FY 2012; on average patients at Maryland Hospitals paid \$12,199 for a hospital admission in FY 2013, up from the \$11,984 paid in FY 2012.
- The cost per admission in Maryland hospitals increased by 3.3% in FY 2013.
- From 1977 through 2012, Maryland experienced the seventh lowest cumulative growth in cost per adjusted admission of any state in the nation.
- Profits on regulated activities decreased in FY 2013 from \$781 million in FY 2012 to \$677 million in FY 2013.
- Profits on operations, both regulated and unregulated, decreased from \$315 million in FY 2012 to \$164 million in FY 2013.
- Maryland total profits increased substantially in FY 2013 from \$230 million or 1.7% in FY 2012 to \$549 million or 3.90% in FY 2013.
- Maryland hospitals provided \$1.1 billion of uncompensated care in FY 2013.

Mr. Phelps noted that next year’s financial disclosure report will be revised to be consistent with the per capita approach of the new waiver.

**ITEM VIII**  
**HEARING AND MEETING SCHEDULE**

December 10, 2014	Time to be determined, 4160 Patterson Avenue HSCRC Conference Room
January 14, 2015	Time to be determined. 4160 Patterson Avenue HSCRC Conference Room

There being no further business, the meeting was adjourned at 2:11 pm.

# **Executive Director's Report**

## **Health Services Cost Review Commission**

### **December 10, 2014**

#### **Global Budget Results and Projections**

After the November Commission meeting, we received compliance projections from all hospitals. Hospitals outlined their plans to be in compliance with December 31 mid-year targets. While volume trends in December could affect the actual results, each hospital expressed its intent to comply with the targets.

Staff is still working on utilization trend analysis derived from the case mix data for presentation to the Commission. We are in the process of receiving corrections on some of the data and determining how to present volume trends on cancer drugs and radiation therapy, which have historically been a challenge due to "cycle billing".

#### **Update on University of Maryland St. Joseph Medical Center**

##### ***Situation--***

The HSCRC staff is evaluating a request from the University of Maryland St. Joseph Medical Center (the Hospital) for a market share adjustment and an advance on this adjustment. The HSCRC staff is also evaluating the Hospital's financial performance, as the Hospital indicates that it has been experiencing accelerating financial losses.

##### ***Background--***

The Hospital, located in Towson, Maryland, was formerly operated by Catholic Health Initiatives. On December 1, 2012, University of Maryland Medical System acquired all the assets of St. Joseph Medical Center from Catholic Health Initiatives and renamed the Hospital the University of Maryland St. Joseph Medical Center.

Before the acquisition, the Hospital was experiencing financial losses and loss of long-time patients stemming from the issue of heart stents. During the fiscal year ended June 30, 2014, HSCRC staff met with management of the Hospital as well as representatives of University of Maryland Medical System to discuss the Hospital's financial performance, given that the Hospital was continuing to report losses.

HSCRC and the Hospital entered into a Global Budget Revenue agreement. This agreement was maintained separately from the remainder of the University of Maryland Medical System hospitals to enable ongoing evaluation of the Hospital in light of potential changes and the Hospital's financial performance. During the negotiation and calculation of the global budget, the Hospital showed volume growth for the first six months of fiscal year 2014 (July through December 2013). In establishing the global budget for the Hospital, HSCRC staff provided a volume adjustment recognizing the growth through December, consistent with the approach used for all GBR calculations.

### *Analysis--*

In the second half of the fiscal year (January 2014 through June 2014), the Hospital experienced significant additional volume growth. As a result, the Hospital has requested a market share adjustment relative to this growth, under the provisions of the GBR agreement. The Hospital submitted a calculation of its estimated market share growth. HSCRC staff has been evaluating the change in in-state volumes using an approach that focuses on making a determination that the change in volumes represents a "shift" from another regulated facility and not just growth in volumes. Using this approach, HSCRC staff has determined preliminarily that there has been a market share shift to the Hospital, with additional patients using the Hospital. When applying a 50% variable cost factor to the volume change, HSCRC staff calculates a potential net increase of approximately \$10 million for the six month period. Staff notes that a portion of the increase is from out of state.

In negotiating GBR agreements, HSCRC staff informed hospitals that it did not anticipate making market shift adjustments for the year ended June 30, 2014. However, given the financial condition of University of Maryland St. Joseph Medical Center and the rapid rise in its volumes in the first six months of the fiscal year, the HSCRC staff entertained this possibility when evaluating the Hospital's GBR. Revenue neutrality is the desired goal for market shift adjustments. In developing GBR budgets for several of the surrounding hospitals that compete with the University of Maryland St. Joseph Medical Center, HSCRC staff did not provide population adjustments for these facilities for the January through June 2014 period, because these facilities were showing volume decreases in the first half of the fiscal year. HSCRC staff expects that these "withholds" from area hospitals will contribute toward funding the FY 2014 market shift adjustment, if provided.

University of Maryland St. Joseph Medical Center has indicated that its volume growth has continued to accelerate in FY 2015, thereby increasing its losses. As a result, it has requested a market share advance for FY 2015. HSCRC staff has recently obtained the case mix data to evaluate the request.

In evaluating the financial condition of the Hospital, the HSCRC staff reviewed the monthly financial statement (FS) schedules, the annual filing, and the audited financial statements for the year ended June 30, 2014. The HSCRC staff has also reviewed the monthly FS schedules for FY 2015. For the year ended June 30, the Hospital generated a small operating income from regulated activities, while sustaining a loss from unregulated and non-operating activities. The audited financial statements presented additional losses at the System level not included in the financial reporting to HSCRC. The HSCRC staff determined that there were significant losses from physician-provided services that are not regulated by HSCRC. HSCRC staff has requested information from the Hospital regarding these losses, including information regarding plans for reducing the losses. HSCRC staff met with representatives of the Trustees of the Hospital to discuss the financial and operating performance of the Hospital and the factors leading to its financial performance.

For FY 2015, the HSCRC staff noted that expenses appeared to be growing in excess of volume growth. We noted that the unaudited FS schedules did not adequately separate regulated and unregulated activities. Staff requested several corrections and improvements to the classifications presented in these statements, and the Hospital resubmitted the statements on December 5, 2014. Staff has also requested to review details of cost growth and cost performance benchmarks, as well as other information.

#### ***Conclusion--***

Staff intends to continue to evaluate the current financial performance, the Hospital's plans for financial improvement, and the possibility of a market shift adjustment for the year ended June 30, 2014. The HSCRC staff will evaluate the market shift for FY 2015 to date and continue to evaluate the Hospital's financial performance. If warranted, the HSCRC staff will consider the request for an advance of the market shift adjustment by the Hospital, in light of its financial condition. HSCRC staff will work diligently to complete this analysis. Staff will report its activities on this matter at the next Commission meeting.

#### **Maryland Hospital Association Request**

On December 8, Staff received a request from the Maryland Hospital Association requesting a mid-year rate update for infrastructure investment. HSCRC staff does not agree with the characterization of the FY 2015 update outlined in the letter, which does not discuss the impact of the MHIP assessment reduction and uncompensated care reduction in lowering hospital rates. These reductions were the result of enrollment expansion and are critical in matching the DSH reductions being made by Medicare. Given the improved financial performance of hospitals and the pace and magnitude of change in uncompensated care levels resulting from Medicaid enrollment expansion under the ACA, HSCRC staff did not expect to make a mid-year

adjustment. Nevertheless, HSCRC staff will take up the discussion with the Payment Work Group, together with the evaluation of uncompensated care and other impacts of enrollment expansion. This may take some time, and we do not expect to have a recommendation for the January Commission meeting. We will, however, update the Commission on the Payment Workgroup discussion.

### **Staff Focus**

During the month of December and January, staff expects to focus on finalizing the quality programs and to continue its focus on market shift calculations.

The Payment workgroup is focused on the market share adjustment. We will also begin to address uncompensated care, the 2016 update, and other topics.

The care coordination work group will have its second meeting this week. Recommendations are anticipated by March.

Provider alignment efforts are resuming this month, with the assistance of HMA and other consulting resources. We will provide more detail on plans and timelines at the January Commission meeting.



Maryland  
Hospital Association

December 5, 2014

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

Dear Chairman Colmers:

At its June 11, 2014 public meeting, the Health Services Cost Review Commission (HSCRC) voted to establish “the update factor for a 6 month period to allow for consideration of calendar year performance...(to) monitor and review results on an ongoing basis and make changes as needed on January 1<sup>st</sup>.” Furthermore, the “Commissioners decided to postpone additional infrastructure funding until January, when better information will be available on the first year status of the waiver and the effectiveness of the initial infrastructure funding can be evaluated.”<sup>1</sup> As we near completion of the first full year under the state’s new all-payer demonstration model, it is important to recall the final recommendations from the HSCRC’s Advisory Council, which advised the Commission to “...*strike a balance between near-term cost control, which is paramount, and making the required investments in physical and human infrastructure necessary for success. If we do not meet the near-term targets, there will be no long-term program. But, if we fail to make the needed infrastructure investments, we will not have the toolkit of reforms necessary to achieve lasting success*” and “(g)iven the challenging targets in this initiative, goals should be set in the aggregate as close to the targets as practicable based on the degree of comfort that individual targets will be met.”<sup>2</sup> There is sufficient information now available to the Commission to re-visit its original action. On behalf of our 65 hospital and health system members, the Maryland Hospital Association (MHA) requests that the Commission increase rates statewide, by 0.75 percent, effective January 1, 2015. We make this request in light of the following:

**1) Maryland’s hospitals have outperformed the limits**

Maryland’s hospitals will significantly outperform the all-payer model limits in the first calendar year. Projected Maryland hospital spending per capita for the year is 2.01 percent - 44 percent below the waiver’s 3.58% per capita limit. Further, although the five-year cumulative savings requirement of \$330 million did not anticipate savings in the first year of the new model, Center for Medicare & Medicaid Innovation data show Maryland’s hospitals on target to generate between \$30 million and \$40 million of savings this year alone. The

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<sup>1</sup> Minutes of the 509<sup>th</sup> meeting of the Health Services Cost Review Commission, June 11, 2014

<sup>2</sup> Advisory Council final report dated January 31, 2014, p.6



results of calendar year 2014 are clear: Maryland's hospitals are outperforming the financial targets of the new model.

- 2) **A January 1 rate adjustment creates no risk of exceeding the waiver's financial limits**  
Aggregate Maryland hospital revenue is capped under the Global Budget Revenue /Total Patient Revenue (GBR/TPR) payment model. Under the old waiver, hospital revenues increased as volume increased, so limiting hospital rates did not guarantee hospital revenue control. This is no longer the case: *hospital revenues cannot exceed the collective GBR/TPR caps*. A January 1 increase in rates does not threaten Maryland's ability to meet the new waiver's revenue ceiling. The GBR/TPR methodologies cap revenue, both prices and volume, providing stable and predictable costs for payers no longer at risk for increased hospital volume. Moreover, when the original update was considered last June, not all hospitals had completed individual global budget contracts with the Commission that would ensure individual spending ceiling compliance; those agreements are now in place in every hospital in the state, with all applicable Maryland hospital revenues capped.

- 3) **Investing in care coordination and population health infrastructure is essential to waiver success**

The spending limits included in the new waiver along with the global budget limits were intended to be aggressive, creating incentives for hospitals and health systems to dramatically change the way they provide hospital care and health care in their communities. And that is exactly what is happening in Maryland. But moving rapidly from volume-based to value-based payment requires significant and immediate change and investment in new health care delivery models. A January 1 rate adjustment would help ensure and speed the needed investments. The HSCRC Advisory Council underscored to this Commission the essential investment in care coordination activities needed for Maryland to be successful under the new waiver, including activities outside the regulated hospital environment. Care coordinators, community health workers, transportation services, behavioral health services, population health-related information technology and data analytics are just a few examples of the new investments required for the five year success under the new model. The need for these investments was acknowledged by the Commission, when GBR hospitals received slightly higher global budgets to help fund needed new infrastructure. As Maryland's hospitals will significantly outperform the all-payer financial requirements this year, now is the time to release additional funds by way of a mid-year rate increase to facilitate those investments.

- 4) **Hospital margins have improved, but remain vulnerable**

As reflected in the attached chart, hospital operating margins have increased this year, but previous declines in 2012 and 2013, forced severe operational cutbacks and created for hospitals an unstable financial footing. As Maryland's hospitals embrace the new value-based model, they must do better with less, controlling health care spending in accordance

with the triple aim. However, hospitals are only beginning to recover from these recent downturns and a six-year history of below-inflation updates.

Maryland's hospitals are doing their part to meet the objectives of the waiver and lower health care costs for everyone. But all stakeholders, including health plans and the public, share responsibility for transforming care in Maryland. A 0.75 percent mid-year rate increase balances population health investment needs with cost containment. Maryland hospital financial performance is well below the waiver's ceiling. We ask the state and the HSCRC to partner with hospitals to invest now to leverage even greater savings and performance improvement as the new waiver model evolves.

We appreciate the Commission's consideration of this critically important issue. If you have any questions, please contact me.

Sincerely,

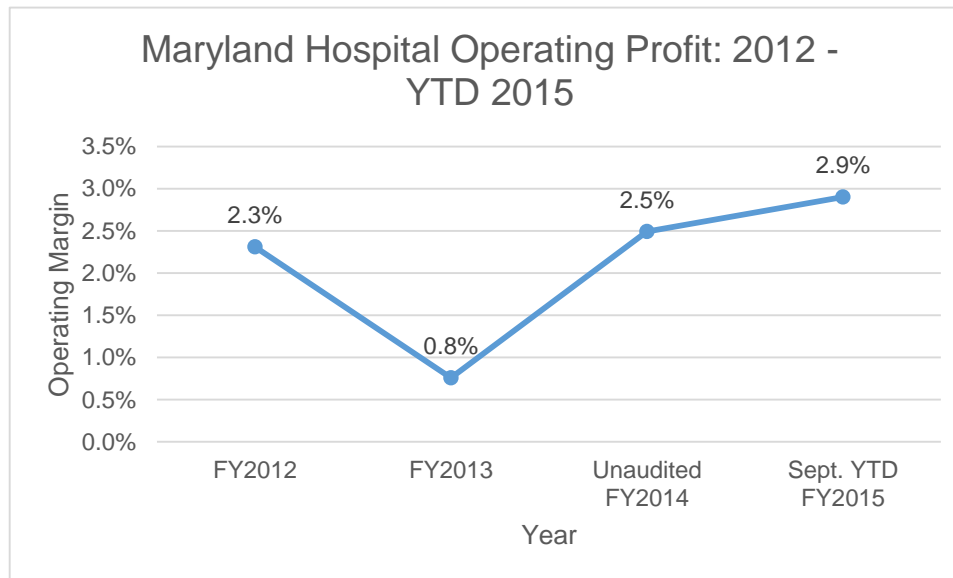
Carmela Coyle  
President & CEO  
Maryland Hospital Association

Attachment

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

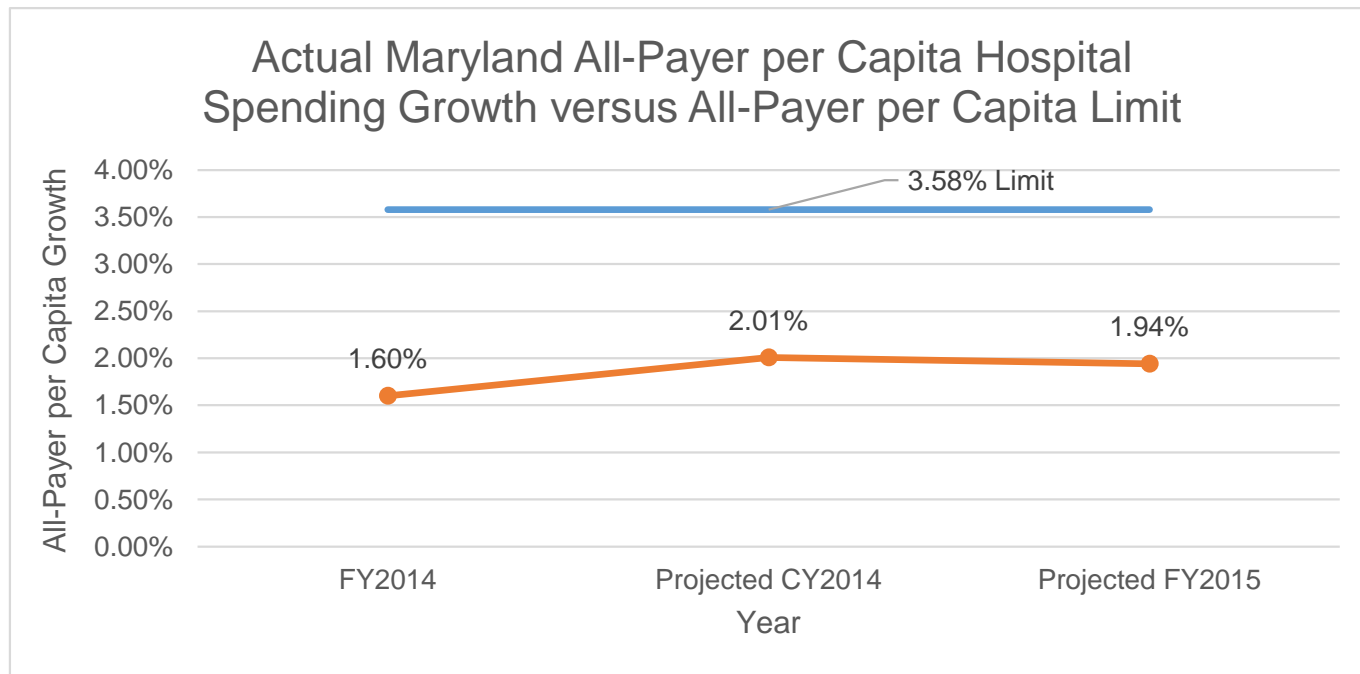
# Operating Margins

- Hospital operating margins are below the traditional 2.75 percent target
  - Neither one year (FY 2014), nor three months (FY 2015), are sufficient to reflect stable profitability



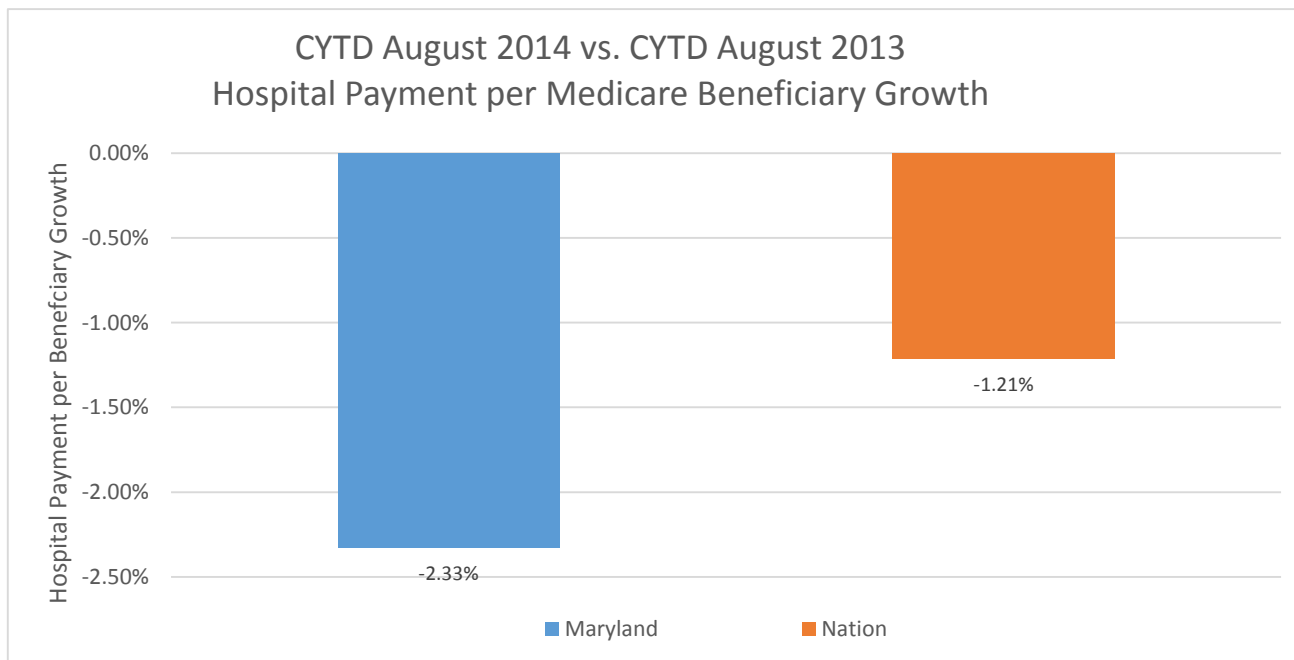
# All-Payer per Capita Growth

- Maryland's hospitals are significantly below the 3.58 percent limit, and will continue below the limit through FY 2015



# Growth in Medicare Hospital Payment per Beneficiary

- Maryland Medicare Hospital Payment per Beneficiary is growing slower than the national average.
  - Maryland's hospitals are expected to generate savings in year one, exceeding the model's requirement for year one.





# Monitoring Maryland Performance Financial Data

Year to Date thru October 2014



**HSCRC**

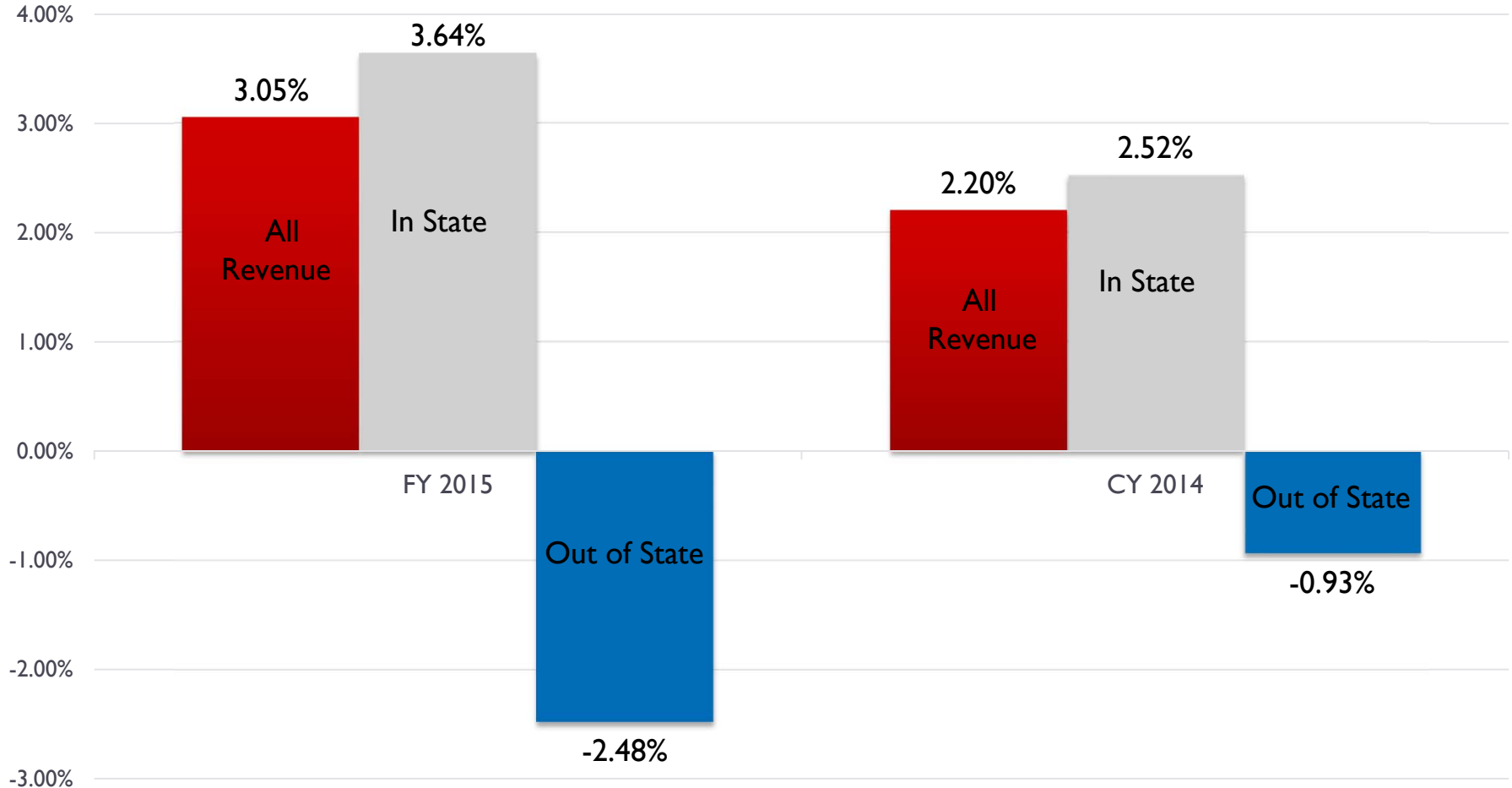
Health Services Cost  
Review Commission

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# Gross All Payer Revenue Growth

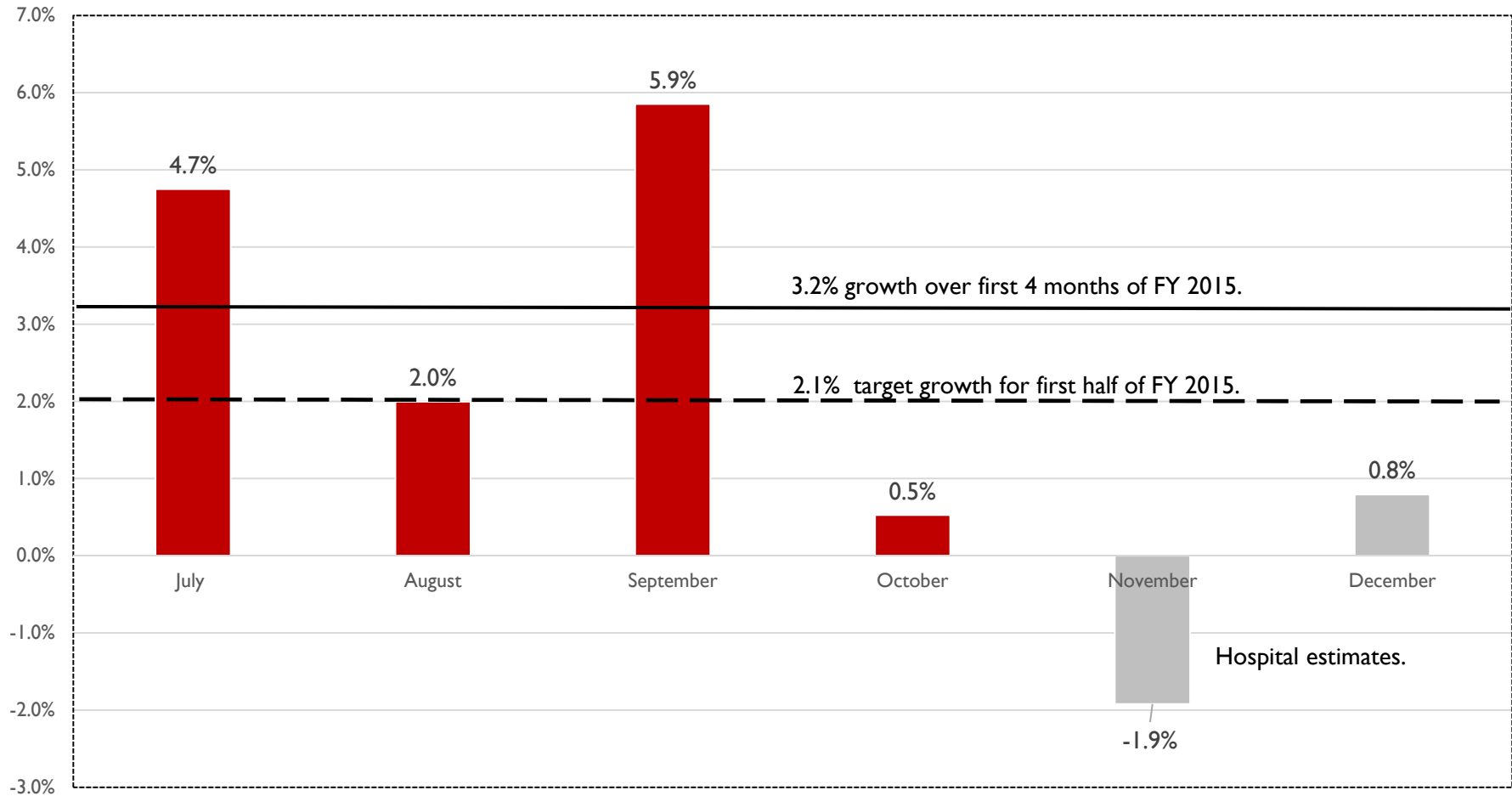
Year to Date (thru October 2014) Compared to Same Period in Prior Year

## All-Payer Year-to-Date Gross Revenue Growth



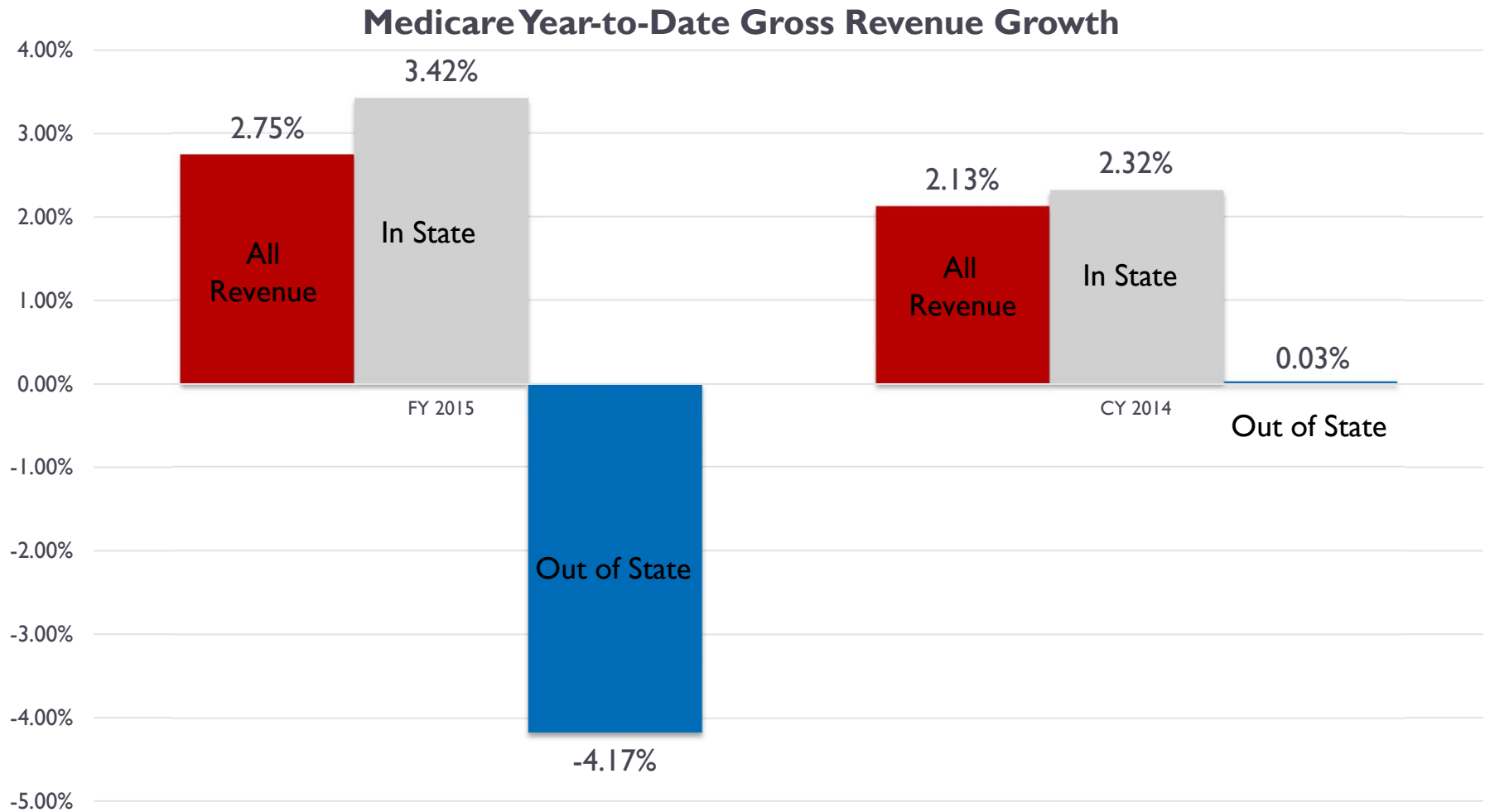
# Hospitals Project Compliance with Global Targets for July – December Adjustments to Charges Expected to Slow Growth in Final Two Months of Year

Monthly Global Budget Revenue Growth in FY 2015 over Same Month in Prior Year



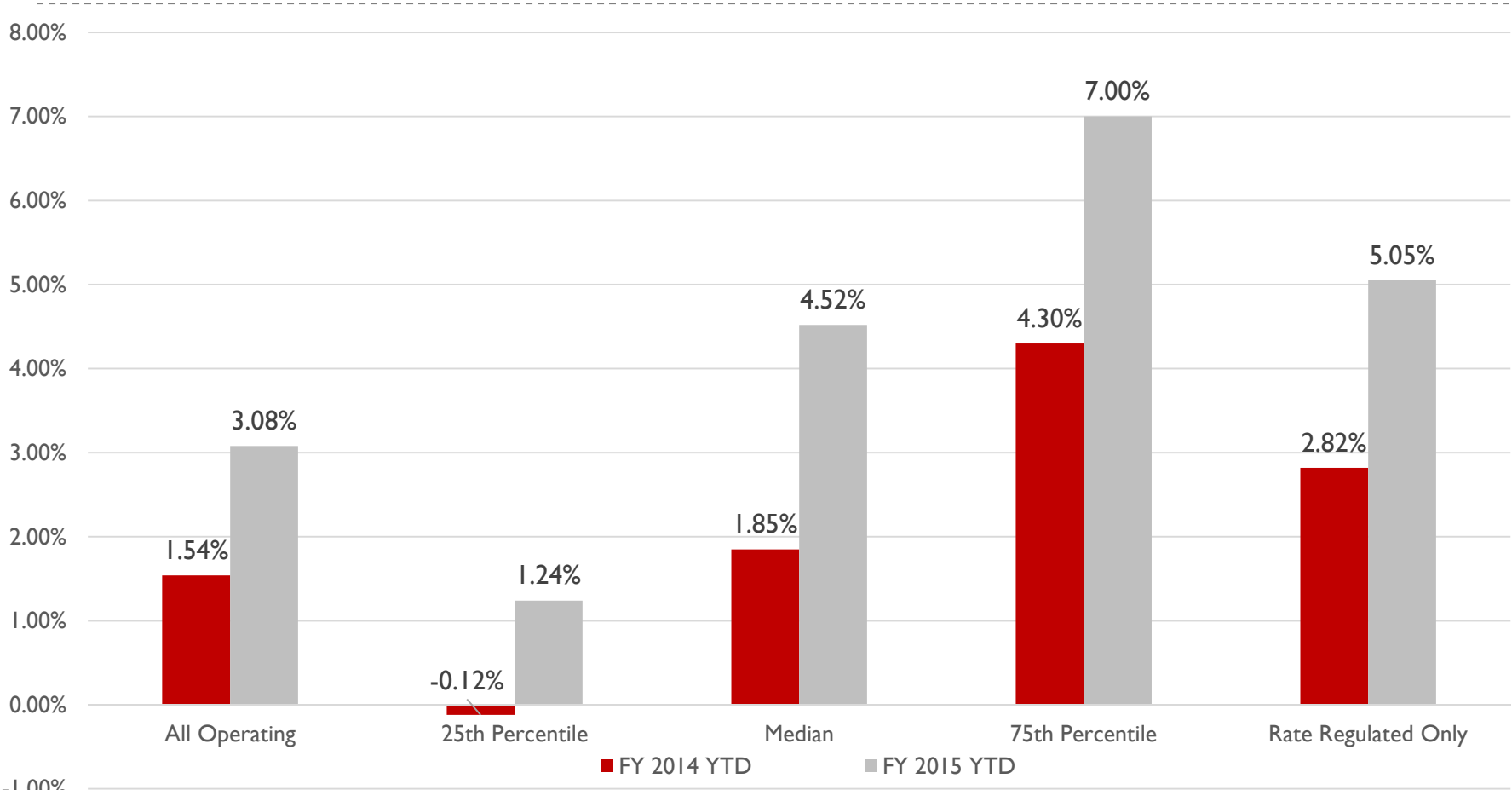


## Gross Medicare Fee-for-Service Revenue Growth Year to Date (thru October 2014) Compared to Same Period in Prior Year





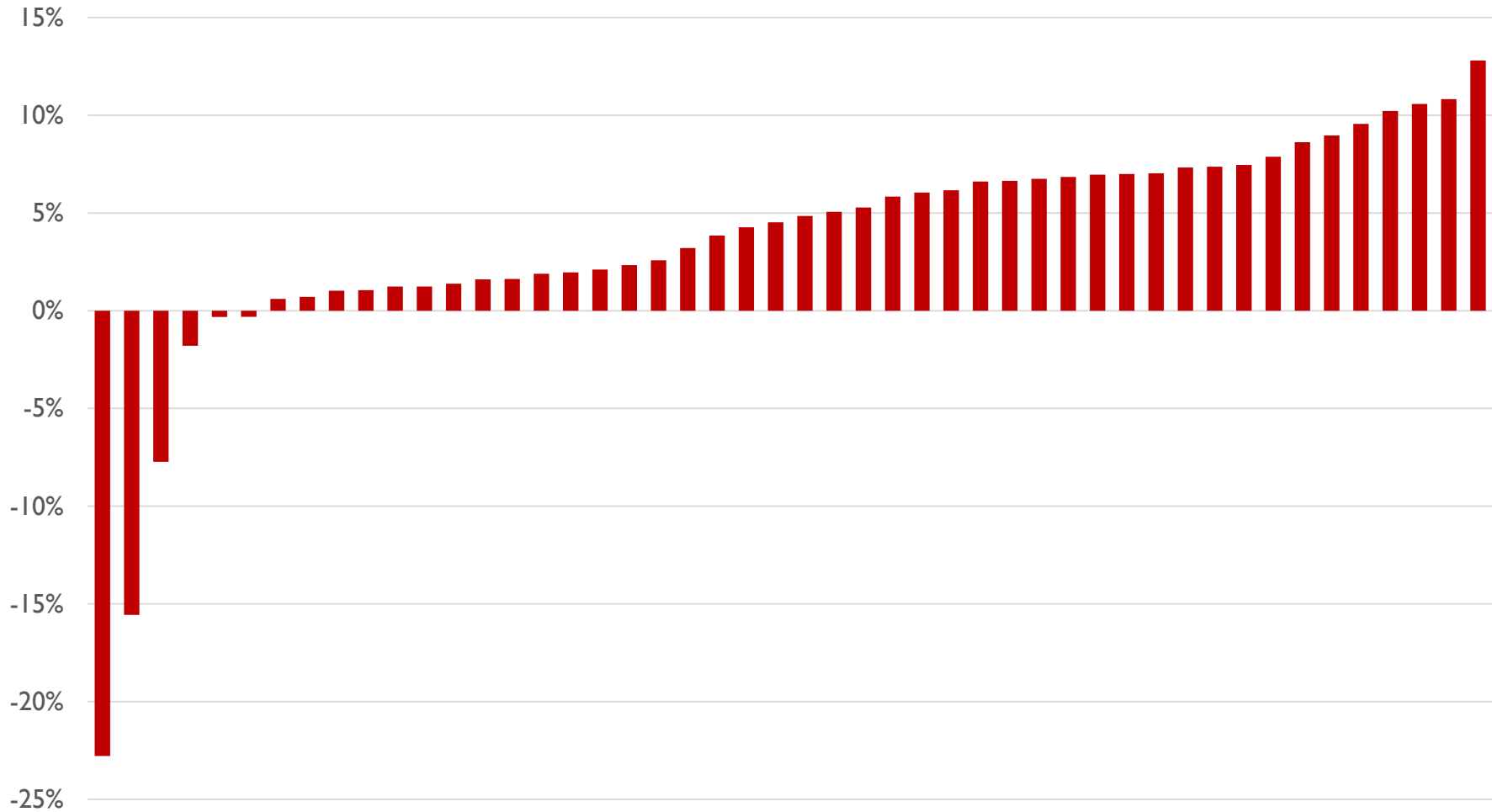
# Operating Profits: Fiscal 2015 Year to Date (July-Oct.) Compared to Same Period in FY 2014



- Year-to-Date FY 2015 hospital operating profits improved compared to the same period in FY 2014.

# Operating Profits by Hospital

Fiscal Year to Date (July – October)



## Purpose of Monitoring Maryland Performance

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**Evaluate Maryland's performance against All-Payer Model requirements:**

- **All-Payer total hospital per capita revenue growth ceiling** for Maryland residents tied to long term state economic growth (GSP) per capita
  - 3.58% annual growth rate
- **Medicare payment savings** for Maryland beneficiaries compared to dynamic national trend. Minimum of \$330 million in savings over 5 years
- **Patient and population centered-measures** and targets to promote population health improvement
  - Medicare readmission reductions to national average
  - 30% reduction in preventable conditions under Maryland's Hospital Acquired Condition program (MHAC) over a 5 year period
  - Many other quality improvement targets

# Data Caveats

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- Data revisions are expected.
- For financial data if residency is unknown, hospitals report this as a Maryland resident. As more data becomes available, there may be shifts from Maryland to out-of-state.
- Many hospitals are converting revenue systems along with implementation of Electronic Health Records. This may cause some instability in the accuracy of reported data. As a result, HSCRC staff will monitor total revenue as well as the split of in state and out of state revenues.
- ▶ All-payer per capita calculations for Calendar Year 2014 and Fiscal 2015 rely on Maryland Department of Planning projections of population growth of .68%. Medicare per capita calculations use actual trends in Maryland Medicare beneficiary counts as reported monthly to the HSCRC by CMMI.

## Cases Closed

The closed cases from last month are listed in the agenda

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

AS OF DECEMBER 3, 2014

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
2265A	Holy Cross Hospital	9/5/2014	N/A	N/A	N/A	DNP	OPEN
2278A	Johns Hopkins Health System	11/13/2014	N/A	N/A	N/A	DNP	OPEN
2279A	MedStar Health	11/20/2014	N/A	N/A	N/A	DNP	OPEN
2280A	Johns Hopkins Health System	11/21/2014	N/A	N/A	N/A	DNP	OPEN
2281A	Riverside Health	12/2/2014	N/A	N/A	N/A	DNP	OPEN

PROCEEDINGS REQUIRING COMMISSION ACTION - NOT ON OPEN DOCKET



**IN RE: THE APPLICATION FOR  
ALTERNATIVE METHOD OF RATE  
DETERMINATION \*  
JOHNS HOPKINS HEALTH  
SYSTEM  
BALTIMORE, MARYLAND**

**\* BEFORE THE MARYLAND HEALTH  
\* SERVICES COST REVIEW  
COMMISSION  
\* DOCKET: 2014  
\* FOLIO: 2088  
\* PROCEEDING: 2278A**

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**Staff Recommendation  
December 10, 2014**

This recommendation was approved by the Commission at the December 10, 2014 meeting.

## **I. INTRODUCTION**

Johns Hopkins Health System (System) filed an application with the HSCRC on November 14, 2014 on behalf of Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center (the Hospitals) for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System requests approval from the HSCRC for participation in an amended global rate arrangement for solid organ transplant, bone marrow transplant, and cardiovascular services with Olympus Managed Health for a period of one year beginning January 1, 2015.

## **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 new global rates was developed by calculating mean historical charges for patients receiving kidney, bone marrow transplants, and cardiovascular 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 is responsible for billing the payer, collecting payments, disbursing payments to the Hospitals at their full HSCRC approved rates, and reimbursing the physicians. The System contends that the arrangement among JHHC, the Hospitals, and the physicians holds the Hospitals harmless from any shortfalls in payment from the global price contract. JHHC maintains it has been active in similar types of fixed fee contracts for several years, and that JHHC is adequately capitalized to bear the risk of potential losses.

## **V. STAFF EVALUATION**

Staff found that the experience under this arrangement for the last year was favorable.

## **VI. STAFF RECOMMENDATION**

The staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for solid organ, bone marrow transplant, and cardiovascular services for a one year period commencing January 1, 2014. 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.

<b>IN RE: THE ALTERNATIVE</b>	<b>*</b>	<b>BEFORE THE HEALTH</b>	
<b>RATE APPLICATION OF</b>	<b>*</b>	<b>SERVICES COST REVIEW</b>	
<b>MEDSTAR HEALTH</b>	<b>*</b>	<b>COMMISSION</b>	
<b>SYSTEM</b>	<b>*</b>	<b>DOCKET:</b>	<b>2014</b>
	<b>*</b>	<b>FOLIO:</b>	<b>2089</b>
<b>COLUMBIA, MARYLAND</b>	<b>*</b>	<b>PROCEEDING:</b>	<b>2279A</b>

**Final Recommendation**

**December 10, 2014**

This recommendation was approved by the Commission at the December 10, 2014 meeting.

## **I. Introduction**

On November 20, 2014, MedStar Health filed an application for an Alternative Method of Rate Determination pursuant to COMAR 10.37.10.06 on behalf of Franklin Square Hospital, Good Samaritan Hospital, Harbor Hospital, and Union Memorial Hospital (the “Hospitals”). MedStar Health seeks approval for MedStar Family Choice (“MFC”) to participate in a Centers for Medicare and Medicaid Services (CMS) approved Medicare Advantage Plan. MedStar Family Choice is the MedStar entity that assumes the risk under this contract. The Hospitals are requesting an approval for two years beginning January 1, 2015.

## **II. Background**

MFC has been operating a CMS-approved Medicare Advantage Plan under the plan name of MedStar Medicare Choice for the last two years in the District of Columbia. Several months ago CMS granted MFC permission to expand under the same Medicare Advantage plan number to provide coverage to Maryland eligible residents in Anne Arundel, Baltimore, Charles, Howard, Prince George’s, St. Mary’s counties and Baltimore City. The application requests approval for the Hospitals to provide inpatient and outpatient hospital services, as well as certain non-hospital services, in return for a CMS-determined capitation payment. MFC will pay the Hospitals HSCRC-approved rates for hospital services used by its enrollees.

MFC supplied a copy of its contract with CMS and financial projections for its operations in Maryland.

## **III. Staff Review**

Staff reviewed the reviewed the CMS contract and the financial information and

projections for CYs 2015.

#### **IV. Recommendation**

Based on the financial projections and the fact that MFC has achieved favorable financial performance in its Maryland Medicaid's Health Choice Program, staff believes that the proposed arrangement for MFC is acceptable under Commission policy.

Therefore, staff recommends that the Commission approve the Hospitals' request to participate in CMS' Medicare Part C Medicare Advantage Program for a period of one year beginning January 1, 2015. The Hospitals must file a renewal application annually for continued participation.

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

**IN RE: THE APPLICATION FOR  
ALTERNATIVE METHOD OF RATE  
DETERMINATION \*  
JOHNS HOPKINS HEALTH  
SYSTEM  
BALTIMORE, MARYLAND**

**\* BEFORE THE MARYLAND HEALTH  
\* SERVICES COST REVIEW  
COMMISSION  
\* DOCKET: 2014  
\* FOLIO: 2090  
\* PROCEEDING: 2280A**

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**Staff Recommendation  
December 10, 2014**

This recommendation was approved by the Commission at the December 10, 2014 meeting.

## **I. INTRODUCTION**

On November 21, 2014, Johns Hopkins Health System (“System”) filed a renewal application on behalf of its member hospitals, Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, and Howard County General Hospital (the “Hospitals”) requesting approval to continue to participate in a revised global price arrangement with Life Trac (a subsidiary of Allianz Insurance Company of North America) for solid organ and bone marrow transplants and cardiovascular services. The Hospitals request that the Commission approve the arrangement for one year beginning January 1, 2015.

## **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 System hospitals and to bear all risk relating to regulated services associated with the contract.

## **III. FEE DEVELOPMENT**

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

## **IV. IDENTIFICATION AND ASSESSMENT RISK**

The Hospitals will continue to submit bills to JHHC for all contracted and covered services. JHHC is responsible for billing the payers, 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 that 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**

The staff found that the actual experience under the arrangement for solid organ and bone marrow transplants for the last year has been slightly unfavorable; however, staff believes that the Hospitals can still achieve a favorable performance under the 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 the period beginning January 1, 2015. The Hospitals must file a renewal application annually 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 ALTERNATIVE  
RATE APPLICATION OF  
LIFEBRIDGE HEALTH  
ADVENTIST HEALTHCARE, INC.**

**\* BEFORE THE HEALTH  
\* SERVICES COST REVIEW  
\* COMMISSION  
\* DOCKET: 2014  
\* FOLIO: 2091  
\* PROCEEDING: 2281A**

**Final Recommendation**

**December 10, 2014**

This final recommendation was approved this day by Commission action.

## **I. Introduction**

On December 2, 2014, Riverside Health (“Riverside”), on behalf of LifeBridge Health, and Adventist Healthcare (the “Hospitals”), filed an application for an Alternative Method of Rate Determination (“ARM”) pursuant to COMAR 10.37.10.06. The Managed Care Organization (“MCO”) and Hospitals seek approval of Riverside to continue to participate in the Medicaid Health Choice Program. Riverside is the entity that assumes the risk under this contract. While Riverside has participated in the Health Choice program in CY 2013 and 2014, this is its first ARM application with the Commission. The MCO and Hospitals are requesting to implement this contract for one year beginning January 1, 2015.

## **II. Background**

Under the Medicaid Health Choice Program, Riverside, an MCO sponsored partially by the Hospitals, is responsible for providing a comprehensive range of health care benefits to Medical Assistance enrollees. The application requests approval for the Hospitals to provide inpatient and outpatient hospital services as well as certain non-hospital services, in return for a State-determined capitation payment. Riverside pays the Hospitals HSCRC-approved rates for hospital services used by its enrollees. Riverside is a relatively small MCO providing services to 2.2% of the total number of MCO enrollees in Maryland.

The MCO supplied information on its most recent financial experience and its preliminary projected revenues and expenditures for the upcoming year based on the revised Medicaid capitation rates.

### **III. Staff Review**

Staff reviewed the operating financial performance under the contract. Staff reviewed financial information and projections for CYs 2013 and 2014, and preliminary projections for CY 2015. Riverside began operating in February of 2013 – one month into the plan year. Due to start up costs, the MCO's CY 2013 financial experience reported to staff was negative. However, financial performance is expected to be positive in both CYs 2014 and 2015.

### **IV. Recommendation**

While first year performance was negative, one would expect initial start up costs to create strain on financials in the first year of operation. Staff will continue to monitor performance of CY 2014 and 2015 to ensure that projections hold up. Based on the information provided, staff believes that the proposed arrangement for Riverside is acceptable.

**Therefore:**

- (1) Staff recommends approval of this alternative rate application for a one-year period beginning January 1, 2015.**
- (2) Since sustained losses over an extended period of time may be construed as a loss contract necessitating termination of this arrangement, staff will continue to monitor financial performance for CY 2014 and the MCO's expected financial status into CY 2015. Staff recommends that Riverside report to Commission staff (on or before the September 2015 meeting of the Commission) on the actual CY 2014 experience, preliminary CY 2015 financial performance (adjusted for seasonality) of the MCO, as well as projections for CY 2016.**
- (3) Consistent with its policy paper outlining a structure for review and evaluation of**

applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the continued adherence to the standard Memorandum of Understanding with the Hospitals for the approved contract. This document formalizes the understanding between the Commission and the Hospitals, and includes provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the managed care contract, quarterly and annual reporting, the 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 also stipulates that operating losses under managed care contracts may not be used to justify future requests for rate increases.

# Draft Recommendation for Modifying the Maryland Hospital Acquired Conditions Program for FY 2017

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

**December 10, 2014**

This document contains the draft staff recommendations for updating the Maryland Hospital Acquired Conditions (MHAC) Program for FY 2017. Comments may be submitted via hard copy mail to the Commission's address or email to [Dianne.feeney@maryland.gov](mailto:Dianne.feeney@maryland.gov) and are due by COB Monday, 12/22/14.

## **A. Introduction**

The HSCRC quality-based payment methodologies are important policy tools for providing strong incentives for hospitals to improve their quality performance over time.

The MHAC program was implemented in state FY 2011. In order to enhance our ability to incentivize hospital care improvements and meet the MHAC reduction targets in the CMMI All-payer model demonstration contract that began on January 1, 2014, Commission staff developed recommendations with significant changes to the MHAC existing policy within the context of the Performance Measurement and Payment Models Workgroup activity. The Commission approved the updated recommendations at the April 2014 meeting that modified the measurement, scoring and payment scaling methodologies to translate scores into rate adjustments for the MHAC initiative. These updates were effective for performance in calendar year 2014 (beginning January 1, 2014) and are to be applied to FY 2016 rates for each hospital. Among these changes were measuring hospital performance using observed to expected ratio values for each PPC rather than the additional incremental cost of the PPCs measured at each hospital, and shifting from relative scaling to pre-established PPC performance targets for payment adjustments. The revised approach also established a statewide MHAC improvement target with tiered amounts of revenue at risk based on whether or not the target is met, and the allocation of rewards for FY 2016 consistent with the amount of revenue in penalties collected.

This recommendation proposes to continue with the current MHAC initiative methodology for FY 2017 with updates to the policy that allow for rewards not limited to the penalties collected, and to the statewide improvement target for applying tiered scaling amounts.

## **B. Background**

### ***1. Centers for Medicare & Medicaid Services (CMS) Hospital Acquired Conditions (HAC) Program***

The federal HAC program began in FFY 2012 when CMS disallowed an increase in DRG payment for cases with added complications in 14 narrowly defined categories. Beginning in FFY 2015, CMS established a second HAC program, which reduces payments of hospitals with scores in the top quartile for the performance period on their rate of Hospital Acquired Conditions as compared to the national average. In FY 2015, the maximum reduction is one percent of total DRG payments.

The CMS HAC measures for FY 2016 are listed in Appendix I.

### ***2. MHAC Measures, Scaling and Magnitude at Risk to Date***

The MHAC program currently uses 65 Potentially Preventable Complications (PPCs) developed by 3M Health Information Systems.

In the process of developing the MHAC updated recommendations for FY 2016, staff vetted several guiding principles for the revised MHAC program that overlap significantly with those identified by the MHA. They include:

## Draft Recommendation for Modifying the Maryland Hospital Acquired Conditions Program

- Program must improve care for all patients, regardless of payer.
- Breadth and impact of the program must meet or exceed the Medicare national program in terms of measures and revenue at risk.
- Program should identify predetermined performance targets and financial impact.
- First year target for the program must be established in context of the trends of complication reductions seen in the previous years as well as the need to achieve the new All-payer model goal of a 30% cumulative reduction by 2018.
- Program should prioritize high volume, high cost, opportunity for improvement and areas of national focus.
- Program design should encourage cooperation and sharing of best practices.
- Program scoring method should hold hospitals harmless for lack of improvement if attainment is highly favorable.
- Hospitals should have ability to track progress during the performance period.

To achieve a policy that supports the guiding principles, staff's approved recommendations effective for CY 2014 performance and applied to rate year FY 2016(see detailed description in Appendix II) included:

- Using Observed (O)/Expected (E) value for each PPC to measure each hospitals' performance
- Establishing appropriate exclusion rules to enhance measurement fairness and stability.
- Prioritizing PPCs that are high cost, high volume, have opportunity to improve, and are of national concern in the final hospital score through grouping the PPCs and weighting the scores of PPCs in each group commensurate with the level of priority.
- Calculating rewards/penalties using preset positions on the scale based on the base year scores.
- Based on performance trends and CMMI contract goals, establishing annual statewide targets with tiered scaling, with a statewide target set at 8% improvement with 1% of permanent revenue at risk if the target is met, and 4% at risk and no rewards paid if the target is missed; penalties were limited to 0.5% of permanent inpatient revenue statewide.

### C. Assessment

HSCRC continues to solicit input from stakeholder groups comprising the industry and including payers to determine appropriate direction regarding areas of needed updates to the programs. These include the measures used, and the program's methodology components.

The Performance Measurement Workgroup has deliberated pertinent issues and potential changes to Commission policy for FY 2017 that may be necessary to enhance our ability to continue to improve quality of care and reduce costs caused by hospital acquired complications, as well as to achieve the reduction target set forth in the contract with CMMI— a 30% reduction in MHACs over five years. In its October and November meetings, the Workgroup discussed issues related to:

- PPC measurement trends,
- Present on admission (POA) auditing,
- The stability of the PPC measures themselves over time,



Draft Recommendation for Modifying the Maryland Hospital Acquired Conditions Program

- The appropriate time period for establishing benchmarks for FY 2017,
- The reward and penalty structure of the program, and,
- A revised annual statewide reduction target for the MHAC program on which to base tiered payment of rewards and penalties.

1. Updated PPC Measurement Trends

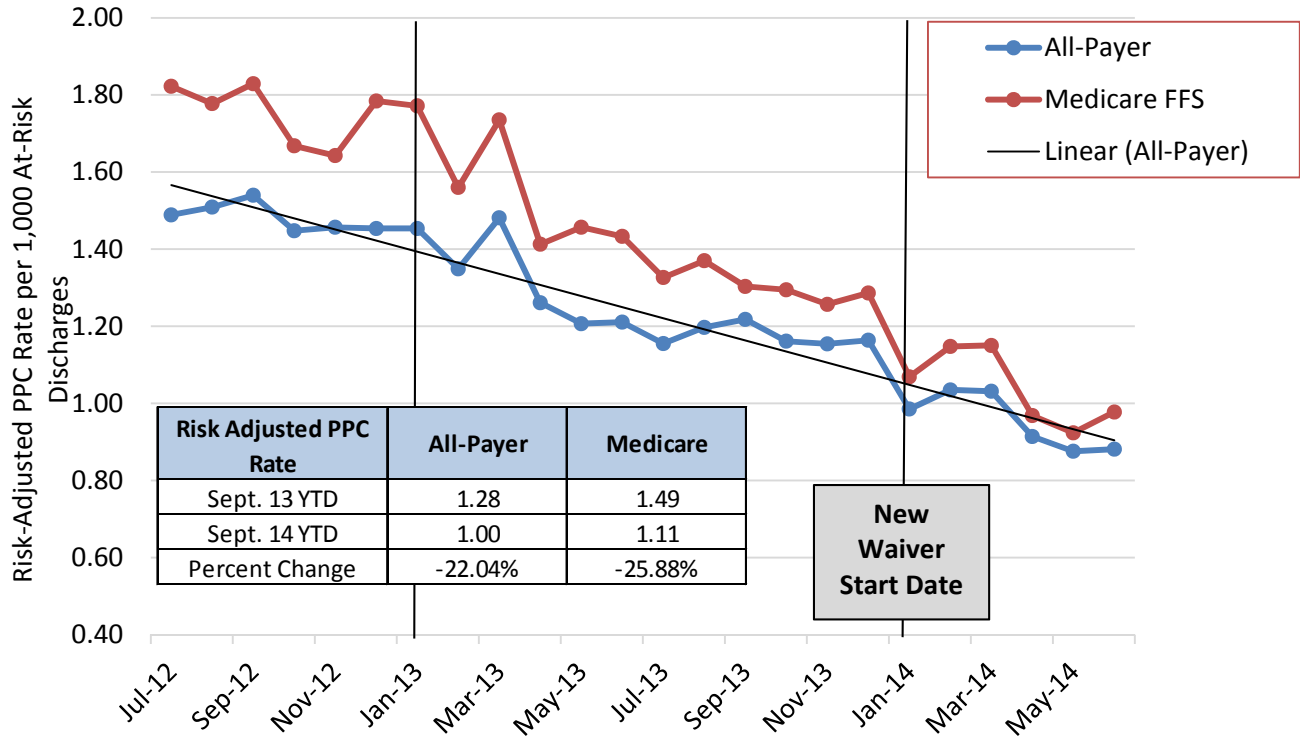
As illustrated in Figure 1 below, Maryland has seen a significant drop from year to year from 2010 to 2014 in the statewide PPC rates with a total rate per 1,000 decrease of 39.6% unadjusted, and an average annual risk adjusted decrease of 13.9%.

Figure 1. PPC Reduction Trends FY 10 to FY 14

Potentially Preventable Complication (PPC) Rates in Maryland- State FY2010-FY2014														
	PPC RATES (FY2010 NORMS, vs. 30)				PPC RATES (CY2013 NORMS, vs. 31)			Annual Change (FY2010 Norms, vs. 30)				Annual Change (CY2013 Norms, vs. 31)	FY2010 Norms, vs. 30	
	FY10	FY11	FY12	FY13	FY13	FY14		FY11	FY12	FY13	FY14	Annual Change	Total Change	
<b>TOTAL NUMBER OF COMPLICATIONS</b>	53,494	48,416	42,118	34,200	34,143	26,900		-9.5%	-13.0%	-18.8%	-21.2%		-15.6%	50.4%
<b>UNADJUSTED COMPLICATION RATE PER 1,000 AT RISK CASES</b>	1.92	1.82	1.65	1.41	1.40	1.16		-5.2%	-9.3%	-14.5%	-17.1%		-11.6%	60.8%
<b>RISK ADJUSTED COMPLICATION RATE PER 1,000 AT RISK CASES</b>	1.92	1.77	1.58	1.30	1.40	1.13		-7.8%	-10.7%	-17.7%	-19.3%		-13.9%	54.7%

In addition to the annual change in PPC rates, staff also analyzed monthly year to date PPC Medicare and all-payer changes and discussed the findings at a public Commission meeting and with the Workgroup. As Figure 2 below illustrates, there was a sharp decrease in the rate in January 2014, but the linear trend line decrease is constant and consistent for September 2013 year to date (YTD) compared to September 2014 YTD.

Figure 2. 2013 and 2014 Monthly YTD PPC Rate Comparisons



Note: Based on final data for January 2013 - June 2014.

## 2. Present on Admission (POA) Auditing

To a very large extent, POA coding drives MHAC assignment. Auditing POA, then, is important in order to validate or discover to what extent that change in PPC rates is related to clinical care rather than hospital coding practices. Staff discussed with the Workgroup modifying the plans for auditing POA in 2014.

- For FY 2014, the HSCRC is primarily focusing on auditing 10 hospitals that have had significant improvements in PPC rates.
- Cases selected for audit (N = 230)
  - 50% random sample for ICD-9 Audits
  - 50% for POA audits (used to be 30%); select from a file of discharges at-risk for PPC's with large improvements and those where the PPC status changed between the preliminary and final data submission.
- Other hospital selection factors include hospital size, date of last audit (not auditing in 2013 or 2014), percent change between preliminary and final data submission.

Staff will present findings of the POA audits in public Workgroup meetings and discuss any implications for considering adjustments to the MHAC program based on the findings.

## 3. Stability of PPC Measures Over Time

Workgroup members expressed concern over the stability of individual PPC measures, in particular noting that some PPCs rates could potentially increase rather than decrease over time

as definitions for the PPCs are potentially interpreted differently from hospital to hospital, and measurement practices evolve over time. “The more you look, the more you find” was an example raised for infection PPCs, as an example.

To explore the question of hospital-specific PPC stability and also that of hospital PPC scores, staff analyzed the correlations for the following performance results:

- Individual PPC rates for FY2012, FY2013, FY2014
- Hospital PPC scores for FY2013 and FY2014, for both improvement and attainment.

Appendix III contains the individual PPC rates per 1,000 correlation results that indicate majority of the PPC rates for hospitals were statistically significantly correlated from FY2012 through FY2014. Figure 3 below illustrates the correlation in improvement and attainment scores that the staff modelled. The results indicate that there was statistically significant correlation for attainment but not for improvement. Based upon these results, staff are less concerned about the stability of measurement of the PPCs but this must continue to be monitored to ensure that the measure is reliable and valid.

**Figure 3. Correlation of FY2013 and FY2014 Improvement and Attainment Scores**

	<b>Correlation Coefficient</b>	<b>p-value</b>
Attainment Scores FY13 and FY14	0.57464	<0.0001
Improvement Scores FY13 and FY14	-0.03931	0.7977

#### **4. *Setting PPC Benchmarks for FY 2017***

The Workgroup discussed issues to consider in setting the base year performance benchmarks. Because of the sharp decrease in PPC rates in January 2014, staff supported the position of setting PPC benchmarks using FY 2014 performance data with an adjustment that recognized the sharp one month decrease; this would entail weighting more heavily the results in the latter 6 months of the fiscal year in setting the benchmarks. However based upon Workgroup concerns with lowering the benchmarks and the sustainability of the current improvement results, the staff will use FY 2014 rates to set benchmarks for FY2017.

#### **5. *MHAC Reward and Penalty Structure***

Staff reviewed with the Workgroup modeling of the rewards and penalties for FY 2016 using data for the first 6 months of CY 2014 (FY2014 Qtrs 3 and 4). A table with hospital specific results can be found in Appendix IV. Workgroup members discussed the impact of a revenue neutrality adjustment to the MHAC program, specifically noting that limiting the rewards to the penalties collected did not recognize the effort expended to achieve the performance levels for the better performing hospitals. As was discussed, Figure 4 below illustrates that total

rewards are reduced to ~10% of what would have been earned if they were not capped at the penalties collected.

Staff will be discussing possibility of removing the cap on rewards at the payment and performance work group meetings in December and provide a final recommendation to the Commission at January meeting.

**Figure 4. MHAC Modeling of Total Rewards and Penalties Using FY 2014 Qtrs 3 and 4 Data**

	<b>Count of Hospitals receiving Reduction or Reward</b>	<b>Total Revenue</b>	<b>Revenue Neutral Adjustment</b>
Total Reduction	5	\$ (1,035,398.00)	\$ (1,035,398.00)
Total Reward	22	\$ 9,901,152.00	\$1,035,398.00

**6. Annual Statewide MHAC Reduction Target and Score Scaling FY 2017**

The Workgroup discussed options for the revised annual MHAC reduction target. Some participants noted that the state has achieved ~23% of that required by the All-payer Model contract with CMMI in the first year. Staff noted the need to continue to improve care and reduce cost. Staff also noted that using FY 2014 to set benchmarks does not account for the additional 6 months from July to December 2014 where the MHAC rates would continue to improve. Therefore, staff advocates for a target of 7% improvement from FY2015 to CY2015, which is equal to 5% annual improvement rate and on par with the improvement trends the state has been observing.

Staff also advocates for no change in the scaling approach by keeping constant the tiered score scaling with no rewards if the statewide target is not met (Appendix V).

**D. Recommendations**

Based on the work completed to date on updating the MHAC program for FY 2017, staff makes the following draft recommendations:

1. The statewide reduction target should be set at 7 % comparing FY2014 to CY2015 risk adjusted PPC rates.
2. The program should continue to use a tiered approach where a lower level of revenue at risk is set if the statewide target is met versus not met as modelled in FY2016 policy
3. Rewards should be distributed only if the statewide target is met, and should not be limited to the penalties collected.

## Appendix I. CMS HAC Measures for FY 2016

### CMS HAC MEASURES Implemented Since FY 2012

HAC 01: Foreign Object Retained After Surgery  
HAC 02: Air Embolism  
HAC 03: Blood Incompatibility  
HAC 04: Stage III & Stage IV Pressure Ulcers  
HAC 05: Falls and Trauma  
HAC 06: Catheter-Associated Urinary Tract Infection  
HAC 07: Vascular Catheter-Associated Infection  
HAC 08: Surgical Site Infection - Mediastinitis After Coronary Artery Bypass Graft (CABG)  
HAC 09: Manifestations of Poor Glycemic Control  
HAC 10: Deep Vein Thrombosis/Pulmonary Embolism with Total Knee Replacement or Hip Replacement  
HAC 11: Surgical Site Infection – Bariatric Surgery  
HAC 12: Surgical Site Infection – Certain Orthopedic Procedure of Spine, Shoulder, and Elbow  
HAC 13: Surgical Site Infection Following Cardiac Device Procedures  
HAC 14: Iatrogenic Pneumothorax w/Venous Catheterization

### CMS HAC Measures Implemented FY 2015

- Domain 1- the Agency for Health Care Research and Quality (AHRQ) composite PSI #90 which includes the following indicators:
  - Pressure ulcer rate (PSI 3);
  - Iatrogenic pneumothorax rate (PSI 6);
  - Central venous catheter-related blood stream infection rate (PSI 7);
  - Postoperative hip fracture rate (PSI 8);
  - Postoperative pulmonary embolism (PE) or deep vein thrombosis rate (DVT) (PSI 12);
  - Postoperative sepsis rate (PSI 13);
  - Wound dehiscence rate (PSI 14); and
  - Accidental puncture and laceration rate (PSI 15).
- Domain 2- two healthcare-associated infection measures developed by the Centers for Disease Control and Prevention's (CDC) National Health Safety Network:
  - Central Line-Associated Blood Stream Infection and
  - Catheter-Associated Urinary Tract Infection.

## **Appendix II: PPC Measurement Definitions, Points Calculation, PPC Tiers and Weighting**

### ***Definitions***

The PPC measure would then be defined as:

Observed (O)/Expected (E) value for each measure

The threshold value is the minimum performance level at which a hospital will be assigned points and is defined as:

Weighted mean of all O/E ratios (O/E =1)

*(Mean performance is measured at the case level. In addition, higher volume hospitals have more influence on PPCs' means.)*

The benchmark value is the performance level at which a full ten points would be assigned for a PPC and is defined as:

Weighted mean of top quartile O/E ratio

For PPCs that are never events, the benchmark will be set at 0.

### ***Performance Points***

Performance points are given based on a range between "Benchmark" and a "Threshold", which are determined using the base year data. The Benchmark is a reference point defining a high level of performance, which is equal to the mean of the top quartile. Hospitals whose rates are equal to or above the benchmark receive 10 full Attainment points.

The Threshold is the minimum level of performance required to receive minimum Attainment points, which is set at the weighted mean of all the O/E ratios which equals to 1. The Improvement points are earned based on a scale between the hospital's prior year score (baseline) on a particular measure and the Benchmark and range from 0 to 9.

The formulas to calculate the Attainment and Improvement points are as follows:

- Attainment Points:  $[9 * ((\text{Hospital's performance period score} - \text{threshold}) / (\text{benchmark} - \text{threshold}))] + .5$ , where the hospital performance period score falls in the range from the threshold to the benchmark
- Improvement Points:  $[10 * ((\text{Hospital performance period score} - \text{Hospital baseline period score}) / (\text{Benchmark} - \text{Hospital baseline period score}))] - .5$ , where the hospital performance score falls in the range from the hospital's baseline period score to the benchmark.

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**PPC Tiers: Tier A Scores Weighted 60%, Tier B 40% and Tier C 20%**

Tier A	Tier C
Selected as high cost, high volume statewide plus those that match CMS HAC policy of AHRQ Patient Safety Indicators	Remaining PPCs
3 Acute Pulmonary Edema and Respiratory Failure without Ventilation	1 Stroke & Intracranial Hemorrhage
4 Acute Pulmonary Edema and Respiratory Failure with Ventilation	2 Extreme CNS Complications
5 Pneumonia & Other Lung Infections	12 Cardiac Arrhythmias & Conduction Disturbances
6 Aspiration Pneumonia	13 Other Cardiac Complications
7 Pulmonary Embolism	15 Peripheral Vascular Complications Except Venous Thrombosis
9 Shock	20 Other Gastrointestinal Complications without Transfusion or Significant Bleed
14 Ventricular Fibrillation/Cardiac Arrest	21 Clostridium Difficile Colitis
16 Venous Thrombosis	23 GU Complications Except UTI
24 Renal Failure without Dialysis	25 Renal Failure with Dialysis
28 In-Hospital Trauma and Fractures	26 Diabetic Ketoacidosis & Coma
31 Decubitus Ulcer	29 Poisonings Except from Anesthesia
35 Septicemia & Severe Infections	30 Poisonings due to Anesthesia
37 Post-Operative Infection & Deep Wound Disruption Without Procedure	32 Transfusion Incompatibility Reaction
38 Post-Operative Wound Infection & Deep Wound Disruption with Procedure	33 Cellulitis
40 Post-Operative Hemorrhage & Hematoma without Hemorrhage Control Procedure or I&D Proc	34 Moderate Infectious
42 Accidental Puncture/Laceration During Invasive Procedure	36 Acute Mental Health Changes
49 Iatrogenic Pneumothrax	39 Reopening Surgical Site
54 Infections due to Central Venous Catheters	43 Accidental Cut or Hemorrhage During Other Medical Care
65 Urinary Tract Infection without Catheter	44 Other Surgical Complication - Mod
66 Catheter-Related Urinary Tract Infection	45 Post-procedure Foreign Bodies
	46 Post-Operative Substance Reaction & Non-O.R. Procedure for Foreign Body
	47 Encephalopathy
	50 Mechanical Complication of Device, Implant & Graft
Tier B	51 Gastrointestinal Ostomy Complications
Selected as remaining PPCs with high Medicare percentage (>60%) and high number of Maryland hospitals (>43)	52 Inflammation & Other Complications of Devices, Implants or Grafts Except Va Infection
8 Other Pulmonary Complications	53 Infection, Inflammation & Clotting Complications of Peripheral Vascular Catheter Infusions
10 Congestive Heart Failure	55 Obstetrical Hemorrhage without Transfusion
11 Acute Myocardial Infarction	56 Obstetrical Hemorrhage with Transfusion
17 Major Gastrointestinal Complications without Transfusion or Significant Bleeding	57 Obstetric Lacerations & Other Trauma Without Instrumentation
18 Major Gastrointestinal Complications with Transfusion or Significant Bleeding	58 Obstetric Lacerations & Other Trauma With Instrumentation
19 Major Liver Complications	59 Medical & Anesthesia Obstetric Complications
27 Post-Hemorrhagic & Other Acute Anemia with Transfusion	60 Major Puerperal Infection and Other Major Obstetric Complications
41 Post-Operative Hemorrhage & Hematoma with Hemorrhage Control Procedure or I&D Proc	61 Other Complications of Obstetrical Surgical & Perineal Wounds
48 Other Complications of Medical Care	62 Delivery with Placental Complications
	63 Post-Operative Respiratory Failure with Tracheostomy
	64 Other In-Hospital Adverse Events

**APPENDIX III. Hospital PPC Rate per 1,000 Correlation Results**

PPC Number	PPC Description	Correlation Coefficient FY12-FY13	Correlation Coefficient FY13-FY14	Correlation Coefficient FY12-FY14
1	Stroke & Intracranial Hemorrhage	0.435	0.598	0.558
2	Extreme CNS Complications	0.043	0.345	0.154
3	Acute Pulmonary Edema and Respiratory Failure without Ventilation	0.770	0.695	0.656
4	Acute Pulmonary Edema and Respiratory Failure with Ventilation	0.806	0.866	0.760
5	Pneumonia & Other Lung Infections	0.524	0.453	0.317
6	Aspiration Pneumonia	0.592	0.397	0.362
7	Pulmonary Embolism	0.661	0.593	0.669
8	Other Pulmonary Complications	0.930	0.930	0.900
9	Shock	0.789	0.570	0.579
10	Congestive Heart Failure	0.908	0.870	0.754
11	Acute Myocardial Infarction	0.565	0.237	0.328
12	Cardiac Arrhythmias & Conduction Disturbances	0.933	0.830	0.848
13	Other Cardiac Complications	0.683	0.413	0.339
14	Ventricular Fibrillation/Cardiac Arrest	0.663	0.605	0.630
15	Peripheral Vascular Complications Except Venous Thrombosis	0.347	0.522	0.479
16	Venous Thrombosis	0.797	0.737	0.675
17	Major Gastrointestinal Complications without Transfusion or Significant Bleeding	0.583	0.609	0.524
18	Major Gastrointestinal Complications with Transfusion or Significant Bleeding	0.508	0.032	0.378
19	Major Liver Complications	0.437	0.276	0.149
20	Other Gastrointestinal Complications without Transfusion or Significant Bleeding	0.106	0.118	0.323
21	Clostridium Difficile Colitis	0.652	0.641	0.661
23	GU Complications Except UTI	0.372	0.231	0.431
24	Renal Failure without Dialysis	0.723	0.680	0.582
25	Renal Failure with Dialysis	0.132	0.193	0.426
26	Diabetic Ketoacidosis & Coma	0.568	0.810	0.825
27	Post-Hemorrhagic & Other Acute Anemia with Transfusion	0.685	0.583	0.518
28	In-Hospital Trauma and Fractures	0.242	0.167	0.142
29	Poisonings Except from Anesthesia	-0.074	0.029	-0.079
31	Decubitus Ulcer	0.715	-0.021	-0.068
32	Transfusion Incompatibility Reaction	1.000	-0.023	-0.023
33	Cellulitis	0.664	0.756	0.711



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34	Moderate Infectious	0.691	0.658	0.634
35	Septicemia & Severe Infections	0.503	0.399	0.303
36	Acute Mental Health Changes	0.681	0.705	0.584
37	Post-Operative Infection & Deep Wound Disruption Without Procedure	0.520	0.504	0.699
38	Post-Operative Wound Infection & Deep Wound Disruption with Procedure	0.647	0.275	0.563
39	Reopening Surgical Site	0.570	0.667	0.615
40	Post-Operative Hemorrhage & Hematoma without Hemorrhage Control Procedure or I&D Proc	0.643	0.559	0.517
41	Post-Operative Hemorrhage & Hematoma with Hemorrhage Control Procedure or I&D Proc	0.396	0.346	0.131
42	Accidental Puncture/Laceration During Invasive Procedure	0.725	0.348	0.430
43	Accidental Cut or Hemorrhage During Other Medical Care	0.798	0.761	0.326
44	Other Surgical Complication - Mod	0.272	0.350	0.450
45	Post-procedure Foreign Bodies	0.226	0.126	-0.133
46	Post-Operative Substance Reaction & Non-O.R. Procedure for Foreign Body	0.275	0.359	0.689
47	Encephalopathy	0.610	0.735	0.385
48	Other Complications of Medical Care	0.400	0.443	0.240
49	Iatrogenic Pneumothrax	0.371	-0.014	0.066
50	Mechanical Complication of Device, Implant & Graft	-0.028	0.579	0.103
51	Gastrointestinal Ostomy Complications	0.566	0.856	0.492
52	Inflammation & Other Complications of Devices, Implants or Grafts Except Vascular Infection	0.571	0.273	0.434
53	Infection, Inflammation & Clotting Complications of Peripheral Vascular Catheters & Infusions	0.305	0.562	0.290
54	Infections due to Central Venous Catheters	0.679	0.272	0.368
55	Obstetrical Hemorrhage without Transfusion	0.798	0.831	0.586
56	Obstetrical Hemorrhage with Transfusion	0.820	0.653	0.790
57	Obstetric Lacerations & Other Trauma Without Instrumentation	0.770	0.753	0.496
58	Obstetric Lacerations & Other Trauma With Instrumentation	0.772	0.401	0.369
59	Medical & Anesthesia Obstetric Complications	0.378	0.368	-0.107
60	Major Puerperal Infection and Other Major Obstetric Complications	0.620	0.456	0.478
61	Other Complications of Obstetrical Surgical & Perineal Wounds	0.497	0.495	0.435
62	Delivery with Placental Complications	0.613	0.561	0.621
63	Post-Operative Respiratory Failure with Tracheostomy	0.864	0.559	0.857
64	Other In-Hospital Adverse Events	0.838	0.791	0.686

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65	Urinary Tract Infection without Catheter	0.663	0.861	0.618
66	Catheter-Related Urinary Tract Infection	0.365	0.301	0.209
Statistically Significant at $p < 0.05$				

Results for PPC30 not presented and McGready was removed from analysis.

**APPENDIX IV.**

FY 2014 Q3&Q4 Final Scores Scaling Modeling								
HOSPITAL ID	HOSPITAL NAME	Estimated Inpatient Revenue (FY15*2.6%)	Base Year Score	FINAL WEIGHTED SCORE	% Scaling Adjustment	\$	Revenue Neutral	%
210001	SUBURBAN	\$ 181,410,188	0.14	0.41	-0.17%	\$ (312,776.19)	\$ (312,776.19)	-0.17%
210002	SOUTHERN MARYLAND	\$ 163,208,213	0.29	0.41	-0.17%	\$ (281,393.47)	\$ (281,393.47)	-0.17%
210003	HOWARD COUNTY	\$ 167,386,497	0.19	0.43	-0.10%	\$ (173,158.44)	\$ (173,158.44)	-0.10%
210004	HOLY CROSS	\$ 319,596,342	0.27	0.44	-0.07%	\$ (220,411.27)	\$ (220,411.27)	-0.07%
210005	CARROLL COUNTY	\$ 138,209,278	0.37	0.45	-0.03%	\$ (47,658.37)	\$ (47,658.37)	-0.03%
210006	GARRETT COUNTY	\$ 18,724,074	0.69	0.47	0.00%	0.00%	0.00%	0.00%
210008	ANNE ARUNDEL	\$ 310,117,075	0.35	0.48	0.00%	0.00%	0.00%	0.00%
210009	DOCTORS COMMUNITY	\$ 136,225,391	0.34	0.49	0.00%	0.00%	0.00%	0.00%
210010	FREDERICK MEMORIAL	\$ 189,480,763	0.36	0.50	0.00%	0.00%	0.00%	0.00%
210011	WASHINGTON ADVENTIST	\$ 161,698,669	0.40	0.51	0.00%	0.00%	0.00%	0.00%
210012	MONTGOMERY GENERAL	\$ 87,652,208	0.36	0.51	0.00%	0.00%	0.00%	0.00%
210013	PENINSULA REGIONAL	\$ 233,728,496	0.20	0.51	0.00%	0.00%	0.00%	0.00%
210015	G.B.M.C.	\$ 201,533,345	0.21	0.51	0.00%	0.00%	0.00%	0.00%
210016	UNION MEMORIAL	\$ 242,505,500	0.25	0.52	0.00%	0.00%	0.00%	0.00%
210017	HARBOR	\$ 124,002,220	0.45	0.53	0.00%	0.00%	0.00%	0.00%
210018	BALTIMORE WASHINGTON MEDICAL CENTER	\$ 223,155,126	0.28	0.54	0.00%	0.00%	0.00%	0.00%
210019	ST. AGNES	\$ 239,121,566	0.44	0.55	0.00%	0.00%	0.00%	0.00%
210022	FRANKLIN SQUARE	\$ 285,691,170	0.38	0.55	0.00%	0.00%	0.00%	0.00%
210023	SHADY GROVE	\$ 228,731,775	0.51	0.55	0.00%	0.00%	0.00%	0.00%
210024	UNIVERSITY OF MARYLAND	\$ 863,843,449	0.28	0.56	0.00%	0.00%	0.00%	0.00%
210027	DORCHESTER	\$ 25,127,935	0.36	0.57	0.00%	0.00%	0.00%	0.00%
210028	UPPER CHESAPEAKE HEALTH	\$ 148,917,096	0.32	0.57	0.00%	0.00%	0.00%	0.00%
210029	LAUREL REGIONAL	\$ 77,501,975	0.45	0.59	0.00%	0.00%	0.00%	0.00%
210030	ATLANTIC GENERAL	\$ 38,640,762	0.64	0.61	0.00%	0.00%	0.00%	0.00%
210032	HARFORD	\$ 47,089,618	0.31	0.62	0.05%	\$ 24,784	\$ 2,592	0.01%
210033	MERCY	\$ 233,163,594	0.31	0.62	0.05%	\$ 122,718	\$ 12,833	0.01%
210034	JOHNS HOPKINS	\$ 1,292,515,919	0.21	0.62	0.05%	\$ 680,272	\$ 71,138	0.01%
210035	PRINCE GEORGE	\$ 177,243,165	0.46	0.63	0.11%	\$ 186,572	\$ 19,510	0.01%
210037	SINAI	\$ 429,154,679	0.24	0.63	0.11%	\$ 451,742	\$ 47,240	0.01%
210038	WESTERN MARYLAND HEALTH SYSTEM	\$ 184,484,266	0.35	0.63	0.11%	\$ 194,194	\$ 20,308	0.01%
210039	GOOD SAMARITAN	\$ 180,861,011	0.56	0.63	0.11%	\$ 190,380	\$ 19,909	0.01%
210040	EASTON	\$ 94,828,132	0.39	0.64	0.16%	\$ 149,729	\$ 15,658	0.02%
210043	FT. WASHINGTON	\$ 17,776,133	0.50	0.64	0.16%	\$ 28,068	\$ 2,935	0.02%
210044	UNION HOSPITAL OF CECIL COUNT	\$ 67,852,189	0.34	0.67	0.32%	\$ 214,270	\$ 22,407	0.03%
210045	UMMC MIDTOWN	\$ 133,787,811	0.46	0.67	0.32%	\$ 422,488	\$ 44,181	0.03%
210048	NORTHWEST	\$ 142,186,717	0.22	0.67	0.32%	\$ 449,011	\$ 46,955	0.03%
210049	UM ST. JOSEPH	\$ 216,335,128	0.28	0.67	0.32%	\$ 683,164	\$ 71,441	0.03%
210051	MERITUS	\$ 187,434,497	0.22	0.68	0.37%	\$ 690,548	\$ 72,213	0.04%
210055	REHAB & ORTHO	\$ 69,104,846	0.32	0.68	0.37%	\$ 254,597	\$ 26,624	0.04%
210056	CALVERT	\$ 67,385,287	0.51	0.70	0.47%	\$ 319,193	\$ 33,379	0.05%
210057	CHARLES REGIONAL	\$ 76,338,049	0.53	0.74	0.68%	\$ 522,313	\$ 54,620	0.07%
210058	BON SECOURS	\$ 78,212,787	0.61	0.76	0.79%	\$ 617,469	\$ 64,571	0.08%
210060	HOPKINS BAYVIEW MED CTR	\$ 356,396,901	0.32	0.76	0.79%	\$ 2,813,660	\$ 294,234	0.08%
210061	ST. MARY	\$ 69,520,305	0.52	0.77	0.84%	\$ 585,434	\$ 61,221	0.09%
210062	CHESTERTOWN	\$ 29,416,674	0.74	0.78	0.89%	\$ 263,202	\$ 27,524	0.09%
210063	MCCREADY	\$ 3,734,618	0.71	1.00	1.00%	\$ 37,346	\$ 3,905	0.10%
					Total Reduct	\$ (1,035,398)	\$ (1,035,398)	
					Total Award	\$ 9,901,152	\$ 1,035,398	
						0.104573465		

## Appendix V. MHAC Score Tiered Scaling of Final MHAC Scores

Final MHAC Score	Below State Quality Target	Exceed State Quality Target
Scores less than or equal to <b>0.17</b>	<b>-4.00%</b>	<b>-1.00%</b>
0.18	-3.88%	-0.97%
0.19	-3.76%	-0.93%
0.20	-3.65%	-0.90%
0.21	-3.53%	-0.86%
0.22	-3.41%	-0.83%
0.23	-3.29%	-0.79%
0.24	-3.18%	-0.76%
0.25	-3.06%	-0.72%
0.26	-2.94%	-0.69%
0.27	-2.82%	-0.66%
0.28	-2.71%	-0.62%
0.29	-2.59%	-0.59%
0.30	-2.47%	-0.55%
0.31	-2.35%	-0.52%
0.32	-2.24%	-0.48%
0.33	-2.12%	-0.45%
0.34	-2.00%	-0.41%
0.35	-1.88%	-0.38%
0.36	-1.76%	-0.34%
0.37	-1.65%	-0.31%
0.38	-1.53%	-0.28%
0.39	-1.41%	-0.24%
0.40	-1.29%	-0.21%
0.41	-1.18%	-0.17%
0.42	-1.06%	-0.14%
0.43	-0.94%	-0.10%
0.44	-0.82%	-0.07%
0.45	-0.71%	-0.03%
0.46	-0.59%	0.00%
0.47	-0.47%	0.00%
0.48	-0.35%	0.00%
0.49	-0.24%	0.00%
0.50	-0.12%	0.00%
0.51	0.00%	0.00%
0.52	0.00%	0.00%
0.53	0.00%	0.00%
0.54	0.00%	0.00%

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0.55	0.00%	0.00%
0.56	0.00%	0.00%
0.57	0.00%	0.00%
0.58	0.00%	0.00%
0.59	0.00%	0.00%
0.60	0.00%	0.00%
0.61	0.00%	0.00%
0.62	0.00%	0.05%
0.63	0.00%	0.11%
0.64	0.00%	0.16%
0.65	0.00%	0.21%
0.66	0.00%	0.26%
0.67	0.00%	0.32%
0.68	0.00%	0.37%
0.69	0.00%	0.42%
0.70	0.00%	0.47%
0.71	0.00%	0.53%
0.72	0.00%	0.58%
0.73	0.00%	0.63%
0.74	0.00%	0.68%
0.75	0.00%	0.74%
0.76	0.00%	0.79%
0.77	0.00%	0.84%
0.78	0.00%	0.89%
0.79	0.00%	0.95%
<b>Scores greater than or equal to</b>		
<b>0.80</b>	<b>0.00%</b>	<b>1.00%</b>

<b>Penalty threshold:</b>	<b>0.51</b>	<b>0.46</b>
<b>Reward Threshold</b>	<b>No rewards</b>	<b>0.61</b>

\*Minimum and maximum scaling scores based on CY 2013 Final Data Attainment Scores. Not changed for RY17 MHAC Program.

# Draft Recommendation for Updating the Hospital Readmission Reduction Incentive Program for FY 2017

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

**December 10, 2014**

This document contains the draft staff recommendations for updating the Maryland Hospital Readmission Reduction Incentive Program for FY 2017. Comments may be submitted via hard copy mail to the Commission's address or email to [Dianne.feeney@maryland.gov](mailto:Dianne.feeney@maryland.gov) and are due by COB Monday, 12/22/14

## **A. Introduction**

The United States health care system currently experiences an unacceptably high rate of unnecessary hospital readmissions. These excessive readmissions are a symptom of our fragmented payment system and result in considerable unnecessary cost and substandard care quality.

Maryland's readmission rates are high compared to the national levels for Medicare. The Center for Medicare and Medicaid Innovation All-Payer Model Agreement (or "waiver"), which began on January 1, 2014, has established readmission reduction targets that require Maryland hospitals to be equal or below rates of Medicare readmissions by 2018, with annual progress toward this goal. In order to enhance our ability to incentivize hospital care improvements and meet the target, the Commission approved the Hospital Readmission Reduction Incentive Program policy to be applied to FY 2016 rates where hospitals achieving at least a 6.76% inter-hospital readmission reduction target for CY 2014 performance compared to CY2013 performance would earn an additional 0.5% in revenue.

The purpose of this document is to describe the proposed updated Readmission Reduction Incentive Program for FY 2017 designed to provide incentives for hospitals to improve overall care coordination and substantially reduce readmissions.

## **B. Background**

Our fragmented system for reimbursing health services in this country, for the most part, has provided large disincentives for hospitals and other providers to construct efficient and effective coordinated care models.

Since the inception of hospital rate regulation in Maryland, the HSCRC has experimented with innovative methods of hospital reimbursement. Pursuant to the provisions of Health-General Article, Section 19-219 and COMAR 10.37.10.06, the Commission may approve experimental payment methodologies that are consistent with the HSCRC's legislative mandate to promote effective and efficient health service delivery and primary policy objectives of cost containment, expanded access to care, equity in payment, financial stability, improved quality, and public accountability.

. The Global Budget Revenue (GBR) and Total Patient Revenue (TPR) arrangements now in place for all hospitals in the State provide for a fixed amount of revenue a hospital may generate during a particular year. These revenue arrangements provide incentives to construct efficient and effective coordinated care models. (Prior to the GBR, most hospitals participated in an episode payment program that bundled readmissions into the index DRG payment levels.) In May 2013, the Commission approved a Shared Savings Policy where hospital inpatient revenues are reduced by 0.3% of inpatient revenues to provide similar cost savings as the federal Medicare Readmission Reduction program. This amount was scaled based on observed versus expected readmissions levels within each hospital.

In April 2014, the Commission approved a second readmission program to provide a positive adjustment for high performing hospitals that meet pre-determined reduction targets for readmissions.

Based on the discussions at the Performance Measurement Workgroup in 2014, the guiding principles vetted for the Hospital Readmission Reduction Program include:

- Measurement used for performance linked with payment must include all patients regardless of payer.
- Measurement must be fair to hospitals.
- The initial and subsequent years’ targets must be established to reasonably support the overall goal of achieving the reductions needed to be equal or lower than the national Medicare readmission rate by CY 2018.
- Measure specifications used for the program should be consistent with the CMS/CMMI measure of readmissions.

The detailed definitions and key methodology components for RY 2017 are described in Appendix I.

## C. Assessment

### 1. Maryland’s High Readmission Rates

Since access to national Medicare data has been delayed, HSCRC staff was not able to verify trends in Maryland and national readmission rates. CMMI staff is also working on revisions to the proposed Medicare readmission rate for the waiver test to remove planned readmissions from the measure and improve the algorithm to account of breaks in Medicare coverage. We hope to receive updated information during the next several months.

Staff analyzed CMS data comparing Maryland hospitals rates to all US hospitals using CMS’ Hospital Readmissions Reduction Program data for 30-day readmission of patients with pneumonia, heart failure (CHF), heart attack (AMI), hip/knee arthroplasty and chronic obstruction pulmonary disease (COPD). This comparison reveals that the majority of Maryland hospitals have readmission rates above the national average for all conditions measured in the CMS program (Figure 1). Hospital specific rates were also presented to the Performance Measurement Workgroup (Appendix II).

**Figure 1: Maryland Hospitals Excess Readmission Ratios as Measured by the CMS’ Hospital Readmissions Reduction Program and Applied to FFY 2015 Medicare Rates Outside of Maryland**

Hospital Name	Pneumonia	Heart Failure	Acute Myocardial Infarction	Hip/Knee Arthroplasty	Chronic Obstructive Pulmonary Disease
Number of Total Cases	19,363	26,474	9,002	18,204	20,666
Hospital Average Ratio	1.04	1.04	1.02	1.09	1.02
Percent of Hospitals Above National Average	61%	70%	61%	59%	59%

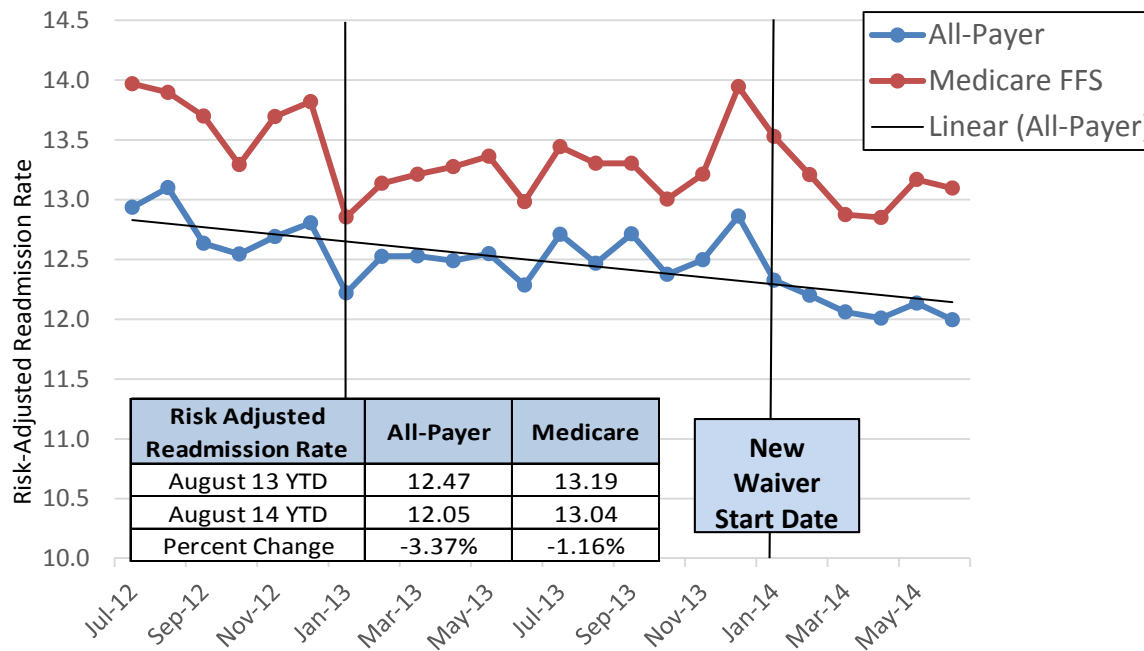
**Data Source:** [FY 2015 IPPS Hospital Readmissions Reduction Program Supplemental Data File \(Final Rule and Correction Notice\)](#)



## 2. Maryland's Progress in Meeting Readmission Reduction Target

Using HSCRC data, staff and the Commission monitor Maryland all-payer and Medicare fee for service monthly readmission trends to assess year to date progress in meeting the established first year hospital specific reduction target of 6.76%. As Figure 2 below illustrates, Maryland's all-payer risk adjusted readmission rate for calendar YTD August 2014 is 3.37% lower than the calendar YTD August 2013 rate.

**Figure 2. All-Payer and Medicare FFS Monthly YTD Readmission Trends**



Note: Line Graph based on final data for January 2013 - June 2014.

## 3. Factors Considered in Updating Annual Target

Staff analyzed data on readmission rates for potential correlations with other factors that may be considered in setting updated hospital-specific and statewide targets. In reevaluating the discussion of setting different targets for hospitals with varying readmission rates, staff found no correlation between readmission rate reductions in the performance and base periods. In examining hospital specific reductions, staff noted that one of the two hospitals with the lowest readmission rates, improved significantly, while the other hospital experienced an increase in readmission rate.

Staff considered patient socioeconomic—e.g., income, education, and occupation— and demographic—e.g., age, race, ethnicity, primary language— (SES/D) factors for making adjustments to the readmission targets that could be applied at the hospital level since these factors influence outcomes through a variety of pathways. There is growing emphasis on SES/D factors as overall quality has improved, but disparities have not, and there are increasing financial stakes for improving quality and disparities. The passage of the IMPACT bill on September 18, 2014 mandates SES-related studies. Ann Greiner, Vice President at the National Quality Forum presented the national developments on using SES/D adjustments in readmission rates at the Performance

Measurement Workgroup October meeting. Although support for using SES/D adjustments is growing, there is not broad consensus on use SES/D adjustment in quality and payment. On one hand, adjusting for SES factors will mask disparities, and on the other hand, there is growing sentiment that adjusting for SES factors is necessary to avoid making incorrect inferences in the context of comparative performance assessment. Staff is committed to working on analyzing the feasibility of adding SES/D adjustments to the readmission reduction incentive policy in the near term and creating a payment adjustment rewarding hospitals with lower readmission rates (based on attainment). In the meantime, staff used percent Medicaid adjustments as a proxy to evaluate the impact of SES on improvements in readmission rates and found no correlation between the two factors. Although SES may impact the absolute readmission rates, evidence on how these factors impact the change in readmission rates is not well developed.

Another factor that staff examined is the relationship between all-payer and Medicare readmission rates. There continues to be a reasonably significant correlation between all-payer and Medicare readmission rates, therefore, setting an all payer target will likely be effective in reducing Medicare readmissions as well. These findings are displayed in Appendix II.

The last factor analyzed is the impact of changes in the denominator on readmission rates. The percent changes in the index admissions appear to have no correlation with the changes in readmission rates. In fact, hospitals that had greatest declines in readmission rates also had greater declines in their denominators (Appendix III).

Changes in inpatient and observation stays due to two-midnight rule continues to be an issue in assessing the trends in national and Maryland readmission rates. In the absence of national claims data, it is difficult to predict the impact and compare Maryland and national trends. The current timelines to receive national claims data is February 2015.

#### *4. Readmission Reduction Target*

Setting targets annually through 2018 continues to be problematic as there are no national projected numbers for admissions or readmissions nor are there projected reduction targets.

According to the all-payer model demonstration contract, "If in a given Performance Year Regulated Maryland Hospitals, in aggregate, fail to outperform the national Readmissions Rate change by an amount equal to or greater than the cumulative difference between the Regulated Maryland Hospital and national Readmission Rates in the base period divided by five, CMS shall follow the corrective action and/or termination [of the exemption from the national Medicare readmissions reduction program] provisions of the Waiver of Section 1886(q) as set forth in Section 4.c and in Section 14."

Staff and stakeholders are concerned with the accuracy of readmission estimates in CMMI data and will work with CMMI to finalize and verify the readmission rates to accurately determine the statewide Medicare readmission reduction target.

#### *5. Payment Incentive Structure*

FY 2016 approved policy provided 0.5 % positive adjustment for hospitals that met or exceeded the improvement target of 6.76%. Appendix IV provides trends in risk adjusted readmission rates

through August 2014. Approximately, one third of the hospitals improved beyond the target. As a result, it is projected that these hospitals will be eligible to receive the reward subject to an confirmation that the improvement is not achieved through a substantial increase in observation cases. On the other hand, one third of hospitals experienced increases in the readmission rates, which is concerning to both staff and stakeholders. Staff is recommending increasing the financial impact of the readmission program by instituting both positive and negative adjustments and placing higher amounts of revenue at risk. In order to align the program with the All-Payer Model Agreement requirements, staff proposes for the payment policy to use a cumulative improvement rate that establishes CY 2013 readmission rates as the base.

In addition, staff is recommending a tiered scaling approach where the financial impact differs based on the State's progress in achieving a Medicare readmission reduction annual target. Figure 3 provides two options for scaling that will be discussed at the Payment and Performance Measurement Workgroup meetings in December.

**Figure 3: Sample Payment Adjustments Scale using Cumulative Benchmark Examples:**  
**Example benchmark=(CY2014 benchmark+1)\*(Cy2015 benchmark+1)-1=(6%+1)\*(4%+1)-1=10%**

Option 1:			Option 2:		
All Payer Readmission Rate Change CY13-CY15	Payment Adjustments		All Payer Readmission Rate Change CY13-CY15	Payment Adjustments	
	Medicare Readmission Reduction Target Not Achieved	Medicare Readmission Reduction Target Achieved		Medicare Readmission Reduction Target Not Achieved	Medicare Readmission Reduction Target Achieved
-10% or LOWER	0.50%	1.00%	-10% or LOWER	0.50%	1.00%
-9.9%	0.00%	0.00%	-9.9%	-0.30%	0.00%
-8%	0.00%	0.00%	-8%	-0.48%	0.00%
-7%	0.00%	0.00%	-7%	-0.57%	0.00%
-6%	0.00%	0.00%	-6%	-0.67%	0.00%
-5%	0.00%	0.00%	-5%	-0.76%	0.00%
-4%	0.00%	0.00%	-4%	-0.86%	0.00%
-3%	0.00%	0.00%	-3%	-0.95%	0.00%
-2%	0.00%	0.00%	-2%	-1.05%	0.00%
-1%	0.00%	0.00%	-1%	-1.14%	0.00%
0%	0.00%	0.00%	0%	-1.24%	0.00%
1%	-0.25%	-0.125%	1%	-1.33%	-0.125%
2%	-0.50%	-0.250%	2%	-1.43%	-0.250%
3%	-0.75%	-0.375%	3%	-1.52%	-0.375%
4%	-1.00%	-0.500%	4%	-1.62%	-0.500%
5%	-1.25%	-0.625%	5%	-1.71%	-0.625%
6%	-1.50%	-0.750%	6%	-1.81%	-0.750%
7%	-1.75%	-0.875%	7%	-1.90%	-0.875%
8%	-2.00%	-1.000%	8%	-2.00%	-1.000%
Higher than 8%	-2.00%	-1.000%	Higher than 8%	-2.00%	-1.000%

## **D. Recommendations**

Staff provides the following draft recommendations for a readmission reduction incentive program for CY 2015 performance applied to rate year 2017:

1. Adapt a payment incentive program with both rewards for hospitals achieving or exceeding the benchmark and payment reductions for hospitals with readmission rate increases or failure to make adequate improvements.
2. Use a tiered approach where a statewide Medicare readmission target must be met to avoid maximum penalties at risk for the program.
3. Continue to set a benchmark for a minimum required readmission rate reduction where rewards may be earned based on all payer readmission reductions.
4. Develop readmission reduction targets for CY 2015 compared to CY 2013 readmission rates by March 2014, taking into consideration the final Medicare rates obtained from CMMI.

## Appendix I. HSCRC Methodology for Readmissions FY2017

### READMISSIONS

CY 2013 inpatient data, with EIDs (base year), is used to calculate the readmission rates for all-payer and Medicare patients.

### EXCLUSIONS

The following were removed from the readmission rate calculations:

1. Rehab hospitals (provider ids 213028,213029, 213300)
2. Cases with null or missing EIDs
3. Duplicates
4. Negative interval days
5. Newborn related APRDRGs.
6. For risk adjustment, based on admission DRGs, exclude DRG and SOI cells with < 2
7. Exclude those who have died (from denominator) and those with same day transfers (interval days = 0) (from readmissions)

### RESULTS

1. Two numerators (readmissions within 30 days of a hospitalization)
  - a. Unadjusted readmissions (comparable to CMS)
  - b. Adjusted readmissions (exclude planned admissions, based on the Clinical Classification System (CCS) to flag planned admissions)
2. Denominator – Total number of discharges
3. Expected Readmissions based on Discharge DRG and Severity of Illness.
4. Calculate Ratio – Adjusted readmissions / expected readmissions
5. Risk Adjusted Readmission Rate – Ratio\*Overall state rate

The key methodology components of the Readmission Reduction Incentive Program are described below.

- **Readmission definition-** Total readmissions/total admissions to any acute hospital<sup>1</sup>
- **Broad patient inclusion-** For greater impact and potential for reaching the target the measure should include all payers and any acute hospital readmission in the state.

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<sup>1</sup> Discharge can both be initial and readmission; one readmission within 30 days is counted; transfers are combined into a single stay; and the 30-day period starts at the end of the combined stay, Left against medical advice is also included in the index. Admissions with discharge status of "Died" are excluded.

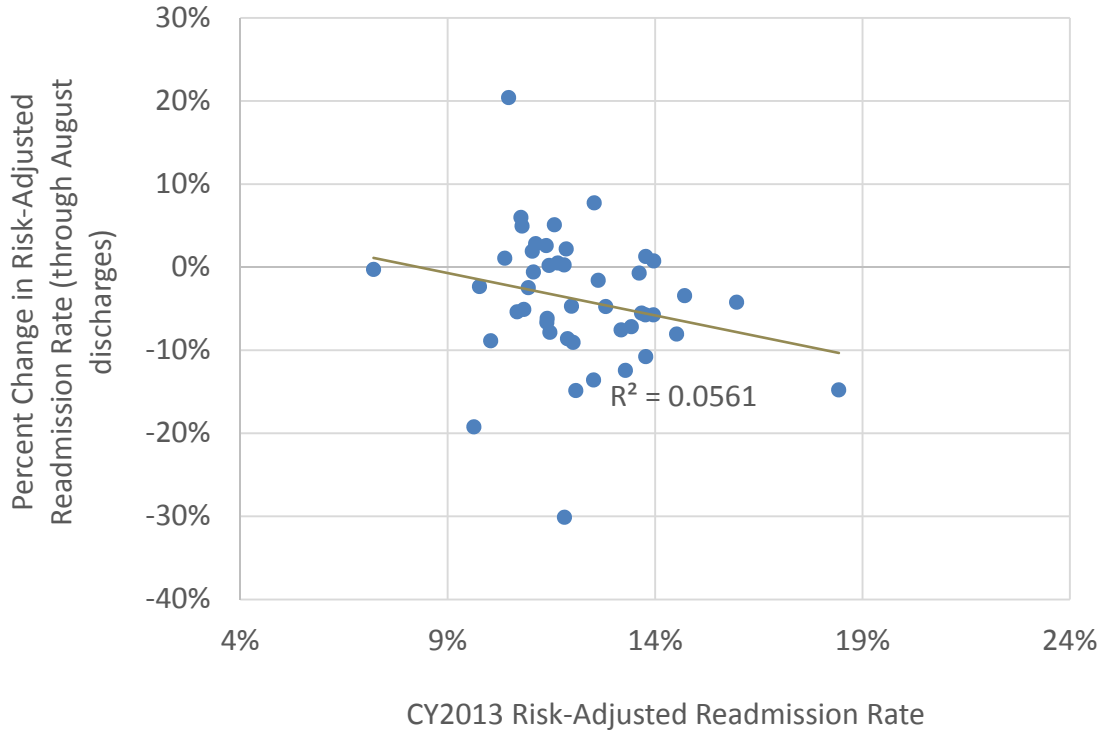
- **Patient exclusion adjustments**– To enhance fairness of the methodology, planned admissions (using the updated CMS Algorithm) and deliveries should be excluded from readmission counts.
  - **Scale positive and negative incentives**- If statewide Medicare readmission reduction target is met, hospitals that reach or exceed the hospital-specific improvement target have the opportunity to earn the incentives and hospital will be assessed penalties if they have an increase in readmission rates. If the statewide Medicare readmission reduction target is not met, hospitals will have an opportunity to earn a reduced incentive, and hospitals will be assessed penalties if they do not meet the minimum improvement target.
  - **Performance measurement consistent across hospitals**- A uniform improvement benchmark for all hospitals was established for the first year and will be evaluated annually. Given the debate whether socio-economic and demographic factors should be used in readmission risk adjustment and that arguments could be made to lower readmission targets for high readmission hospitals if they serve hard to reach populations, staff recommends using a uniform achievement benchmark for all hospitals.
- Monitor for unintended consequences**- Observation and ED visits within 30 Days of an inpatient stay will be monitored; adjustments to the positive incentive will be made if observation cases within 30 days increase faster than the other observations in a given hospital.

## Appendix II. CMS Medicare Readmission Rates for FFY2015

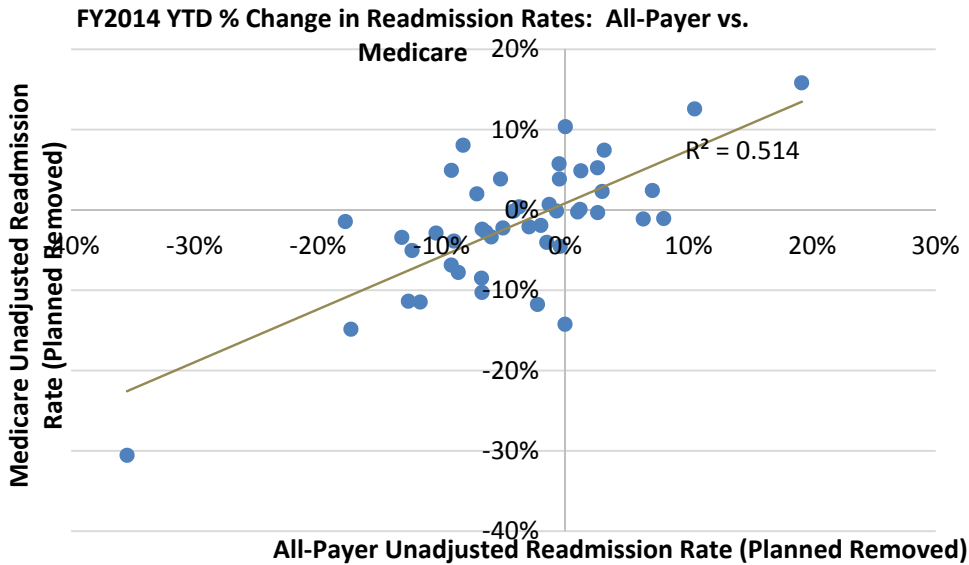
Hospital Name	Number of Pneumonia Cases	Excess Readmission Ratio for Pneumonia	Number of Heart Failure Cases	Excess Readmission Ratio for Heart Failure	Number of Acute Myocardial Infarction Cases	Acute Myocardial Infarction Excess Readmission Ratio	Number of Hip/Knee Arthroplasty Cases	Hip/Knee Arthroplasty Excess Readmission Ratio	Number of Chronic Obstructive Pulmonary Disease Cases	Chronic Obstructive Pulmonary Disease Excess Readmission Ratio	Average
NORTHWEST HOSPITAL CENTER	628	1.21	797	1.20	151	1.07	180	0.92	599	1.15	1.11
DOCTORS' COMMUNITY HOSPITAL	410	1.25	490	1.01	38	0.99	170	1.33	371	0.93	1.10
SINAI HOSPITAL OF BALTIMORE	391	1.09	928	1.02	466	1.01	676	1.38	363	1.00	1.10
MEDSTAR MONTGOMERY MEDICAL CENTER	429	1.04	437	1.17	99	1.10	314	1.15	380	1.05	1.10
SHADY GROVE ADVENTIST HOSPITAL	677	1.07	515	1.09	194	1.04	574	1.23	430	1.07	1.10
SAINT AGNES HOSPITAL	862	1.01	761	1.07	184	0.89	390	1.51	670	1.00	1.10
UNIVERSITY OF MD CHARLES REGIONAL MEDICAL CENTER	348	1.07	428	1.00	25	1.09	190	1.28	608	1.01	1.09
SOUTHERN MARYLAND HOSPITAL CENTER	386	1.12	694	1.07	171	1.08	161	1.03	427	1.14	1.09
UNIVERSITY OF MARYLAND MEDICAL CENTER	165	1.13	329	1.14	512	1.12	57	1.04	122	1.00	1.09
UNIVERSITY OF MD SHORE MEDICAL CTR AT CHESTERTOWN	190	0.96	265	1.01	29	1.03	77	1.33	263	1.10	1.08
MEDSTAR HARBOR HOSPITAL	278	0.91	409	1.16	64	0.97	209	1.30	436	1.06	1.08
LAUREL REGIONAL MEDICAL CENTER	103	1.02	176	1.02	46	1.09	78	1.20	127	1.07	1.08
CALVERT MEMORIAL HOSPITAL	380	1.10	556	1.02	70	0.97	149	1.33	403	0.98	1.08
UNION HOSPITAL OF CECIL COUNTY	353	1.02	290	1.05	87	1.07	206	1.25	590	1.01	1.08
PRINCE GEORGES HOSPITAL CENTER	102	1.10	265	1.11	144	1.06	25	1.00	157	1.11	1.08
MERCY MEDICAL CENTER INC	199	1.06	340	1.03	28	1.09	1037	1.19	239	0.98	1.07
JOHNS HOPKINS BAYVIEW MEDICAL CENTER	485	1.15	850	1.10	181	1.10	432	0.91	575	1.09	1.07
UNIVERSITY OF MD BALTO WASHINGTON MEDICAL CENTER	1014	1.19	1198	1.16	264	0.93	404	0.99	1167	1.06	1.07
MEDSTAR GOOD SAMARITAN HOSPITAL	352	1.25	1037	1.01	150	1.11	578	0.91	518	1.06	1.07
ANNE ARUNDEL MEDICAL CENTER	849	1.08	1151	1.09	365	1.09	1849	1.01	785	1.05	1.06
HOWARD COUNTY GENERAL HOSPITAL	692	1.15	590	1.11	131	0.96	104	1.05	654	1.03	1.06
MEDSTAR FRANKLIN SQUARE MEDICAL CENTER	726	1.00	1297	0.99	314	1.00	308	1.27	1134	1.02	1.06
HOLY CROSS HOSPITAL	391	1.03	607	1.07	142	1.03	314	1.10	373	0.99	1.05
ATLANTIC GENERAL HOSPITAL	297	0.98	311	0.89	27	1.10	232	1.14	369	1.05	1.03
UNIVERSITY OF MARYLAND HARFORD MEMORIAL HOSPITAL	173	1.01	263	0.98	51	1.02	55	1.08	311	1.04	1.03
FREDERICK MEMORIAL HOSPITAL	982	1.04	926	0.98	280	0.99	608	1.05	904	1.05	1.02
CARROLL HOSPITAL CENTER	600	1.04	760	0.98	213	1.01	535	1.10	702	0.98	1.02
UNIVERSITY OF MD SHORE MEDICAL CENTER AT EASTON	558	1.01	931	0.99	105	1.06	511	1.03	779	1.02	1.02
UNIVERSITY OF M D UPPER CHESAPEAKE MEDICAL CENTER	410	0.94	800	1.02	269	1.06	388	1.05	788	0.98	1.01
SUBURBAN HOSPITAL	557	0.97	637	1.04	360	1.02	997	0.95	269	1.06	1.01
CENTER	756	1.05	881	1.05	393	1.02	605	0.94	939	0.98	1.01
WASHINGTON ADVENTIST HOSPITAL	222	1.00	480	1.09	439	1.01	106	0.99	252	0.95	1.01
CENTER	80	0.96	157	0.98	40	1.01	45	1.00	122	1.06	1.00
MEDSTAR SAINT MARY'S HOSPITAL	300	0.92	440	1.08	70	1.00	318	0.88	459	1.02	0.98
GARRETT COUNTY MEMORIAL HOSPITAL	137	0.90	173	1.08	38	0.98	177	0.84	149	1.06	0.97
GREATER BALTIMORE MEDICAL CENTER	569	0.93	540	0.92	47	0.98	510	1.12	369	0.89	0.97
MEDSTAR UNION MEMORIAL HOSPITAL	253	0.97	636	0.94	653	0.99	1146	0.96	308	0.90	0.95
SAINT JOSEPH MEDICAL CENTER	299	1.00	784	0.96	543	0.87	1158	0.98	395	0.94	0.95
UNIVERSITY OF MARYLAND ST JOSEPH MEDICAL CENTER	50	0.95	160	0.96	82	0.97	266	0.93	82	0.93	0.95
MERITUS MEDICAL CENTER	1174	0.97	587	0.99	281	0.91	781	0.78	717	0.99	0.93
PENINSULA REGIONAL MEDICAL CENTER	857	0.91	1290	0.92	734	0.91	931	0.88	670	0.87	0.90
FORT WASHINGTON HOSPITAL	105	0.99	189	1.13	3		71	1.08	148	1.23	1.11
JOHNS HOPKINS HOSPITAL, THE	323	1.10	730	1.02	496	1.06	12		227	0.98	1.04
BON SECOURS HOSPITAL	86	0.99	188	1.06	9		2		112	1.02	1.03
UNIVERSITY OF MD MEDICAL CENTER MIDTOWN CAMPUS	110	1.03	144	1.04	9		14		146	1.00	1.02
EDWARD MCCREADY MEMORIAL HOSPITAL	52	0.96	50	1.00	5		0		56	0.95	0.97
UNIV OF MD REHABILITATION & ORTHOPAEDIC INSTITUTE	3		7		0		254	1.28	2		1.28
LEVINDALE HEBREW GERIATRIC CENTER AND HOSPITAL	0		0		0		0		0		NA
<b>Number of Cases</b>		19,363		26,474		9,002		18,204		20,666	
<b>Hospital Average Ratio</b>		1.04		1.04		1.02		1.09		1.02	1.04
<b>Percent of Hospitals Above National Average</b>		61%		70%		61%		59%		59%	83%

### Appendix III. Analysis of All-Payer Readmission Rate Correlations with Base Period Rate, Medicare Readmission Rate, and Percent Medicaid Admissions

No Correlation of Readmission Reduction Rate of Improvement with Base Year Rate

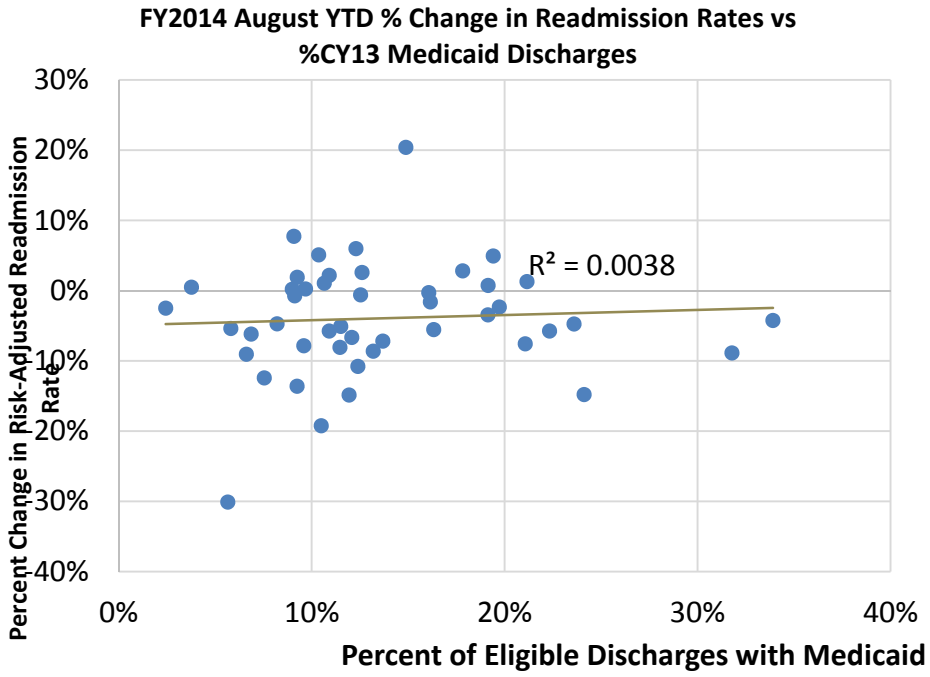


Higher Correlation of Medicare and All-Payer Readmission Rates





### No Correlation in Readmission Rates with % of Medicaid Admissions



## Appendix IV: CY 2014 YTD Readmission Improvement Rates (as of August Discharges)

HOSPITAL ID	HOSPITAL NAME	NUMBER OF ELIGIBLE DISCHARGES CY13 YTD*	NUMBER OF READMISSIONS CY13 YTD	CY13 YTD RISK ADJUSTED RATE	CY14 YTD RISK ADJUSTED RATE	Eligible Discharges % change CY13-CY14 YTD	All-Payer % Change from CY13-CY14 YTD
210045	MCCREADY	193	36	12.94%	9.04%	12%	-30.11%
210039	CALVERT	4,805	455	9.80%	7.92%	-15%	-19.24%
210028	ST. MARY	5,640	653	12.19%	10.38%	-9%	-14.87%
210013	BON SECOURS	3,775	1,072	18.54%	15.80%	-24%	-14.79%
210051	DOCTORS COMMUNITY	6,850	1,083	12.02%	10.39%	-17%	-13.60%
210030	CHESTERTOWN	1,318	244	14.13%	12.37%	-10%	-12.43%
210024	UNION MEMORIAL	8,648	1,463	14.06%	12.54%	-9%	-10.78%
210018	MONTGOMERY GENERAL	5,797	757	11.91%	10.83%	0%	-9.06%
210003	PRINCE GEORGE	7,825	738	10.09%	9.19%	11%	-8.88%
210027	WESTERN MARYLAND HEALTH	8,620	1,082	12.49%	11.41%	-7%	-8.63%
210040	NORTHWEST	6,365	1,179	14.38%	13.22%	12%	-8.07%
210058	REHAB & ORTHO	1,707	192	11.85%	10.92%	-5%	-7.86%
210055	LAUREL REGIONAL	4,219	524	13.11%	12.12%	-17%	-7.57%
210011	ST. AGNES	12,210	1,599	13.07%	12.13%	-3%	-7.19%
210062	SOUTHERN MARYLAND	9,810	1,179	11.28%	10.53%	-6%	-6.66%
210063	UM ST. JOSEPH	10,997	1,157	11.65%	10.93%	11%	-6.18%
210043	BALTIMORE WASHINGTON MEDICAL CENTER	12,198	1,930	13.83%	13.03%	-5%	-5.75%
210008	MERCY	12,843	1,385	13.99%	13.19%	-14%	-5.74%
210012	SINAI	16,823	2,424	13.52%	12.77%	-4%	-5.54%
210044	G.B.M.C.	13,349	1,097	10.59%	10.02%	0%	-5.40%
210057	SHADY GROVE	16,466	1,350	10.84%	10.29%	-2%	-5.10%
210034	HARBOR	6,123	721	12.85%	12.24%	-10%	-4.74%
210023	ANNE ARUNDEL	20,913	1,784	11.87%	11.31%	-5%	-4.72%
210038	UMMC MIDTOWN	4,428	986	15.93%	15.25%	-21%	-4.24%
210029	HOPKINS BAYVIEW MED CTR	13,784	2,215	14.61%	14.10%	-5%	-3.45%
210022	SUBURBAN	8,426	1,034	10.88%	10.61%	1%	-2.49%
210032	UNION HOSPITAL OF CECIL	3,786	436	10.32%	10.08%	-3%	-2.34%
210015	FRANKLIN SQUARE	15,696	2,038	12.76%	12.56%	2%	-1.60%
210056	GOOD SAMARITAN	7,804	1,390	13.31%	13.21%	-14%	-0.73%
210010	DORCHESTER	1,528	226	10.69%	10.63%	-1%	-0.60%
210017	GARRETT COUNTY	1,471	89	7.11%	7.08%	-4%	-0.29%
210049	UPPER CHESAPEAKE HEALTH	8,826	984	11.22%	11.24%	-7%	0.20%
210048	HOWARD COUNTY	12,197	1,162	11.42%	11.45%	4%	0.25%
210061	ATLANTIC GENERAL	2,062	295	11.04%	11.09%	1%	0.48%
210009	JOHNS HOPKINS	32,098	5,134	13.86%	13.97%	-1%	0.74%
210005	FREDERICK MEMORIAL	12,475	1,258	10.43%	10.54%	-8%	1.06%
210002	UNIVERSITY OF MARYLAND	21,587	3,273	13.59%	13.76%	-11%	1.29%
210006	HARFORD	3,079	462	11.00%	11.21%	-7%	1.91%
210033	CARROLL COUNTY	7,876	948	11.79%	12.05%	-3%	2.18%
210001	MERITUS	11,361	1,241	11.24%	11.53%	4%	2.59%
210004	HOLY CROSS	23,172	1,733	11.26%	11.58%	4%	2.82%
210016	WASHINGTON ADVENTIST	8,572	960	10.75%	11.28%	-1%	4.93%
210035	CHARLES REGIONAL	5,550	670	11.52%	12.10%	-4%	5.09%
210019	PENINSULA REGIONAL	12,825	1,380	10.55%	11.18%	-3%	5.98%
210060	FT. WASHINGTON	1,521	208	11.80%	12.71%	-9%	7.74%
210037	EASTON	5,552	507	9.99%	12.03%	-2%	20.40%
	STATE	423,170	52,733	12.43%	12.04%	-4%	-3.18%

# Draft Recommendation for Aggregate Revenue Amount At-Risk under Maryland Hospital Quality Programs for FY 2017

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

**December 10, 2014**

This document contains the draft staff recommendations for the aggregate amount at-risk under Maryland hospital quality programs for FY 2017. Comments may be submitted via hard copy mail to the Commission's address or email to [Dianne.feeney@maryland.gov](mailto:Dianne.feeney@maryland.gov) and are due by COB Monday, 12/22/14

## A. Introduction

The HSCRC quality-based payment methodologies are important policy tools with great potential to provide strong incentives for hospitals to improve their quality performance over time. Each of the current policies for quality-based payment programs holds revenue at risk directly related to specified performance targets.

- The Quality Based Reimbursement (QBR) program employs revenue neutral scaling of hospitals in allocating rewards and reductions based on performance, with the net increases in rates for better performing hospitals funded by net decreases in rates for poorer performing hospitals.<sup>1</sup>
- For the Maryland Hospital Acquired Conditions (MHAC) program, hospital performance is measured using observed to expected ratio values for each component measure and revenue allocations are performed using pre-established performance targets. The revenue at risk and reward structure is based on a tiered approach that requires statewide targets to be met for higher rewards and reduced reductions.
- The Readmission Shared Savings Program reduces each hospital's approved revenues prospectively based on its risk adjusted readmission rates.
- The hospital Readmission Reduction Incentive Program (RRIP) policy initiated in FY 2015 is designed to be a positive incentive program to reward hospitals that achieve a specified readmission reduction target. For FY 2017, staff is proposing to strengthen this program by increasing the amount of revenue at risk and including both rewards and reductions. Similar to the MHAC program, staff is proposing the use of a tiered approach that requires statewide targets to be met for higher rewards and reduced penalties. Potentially Avoidable Utilization reductions are applied to global budgets to reduce allowed volume growth based on percent of revenue associated with potentially avoidable utilization for each hospital.

This draft recommendation proposes the amount of hospital revenue at-risk for the following programs: 1. Quality-Based Reimbursement; 2. Maryland Hospital Acquired Conditions; and, 3. Readmission Reduction Incentive Program.

The Shared Savings for Readmissions<sup>2</sup> and Potentially Avoidable Utilization programs that also hold revenue at risk based on performance are determined annually commensurate with the hospital rate update factor process.

## B. Background

Maryland has been a leader in initiating quality based payment approaches. Historically, these programs have surpassed the requirements of similar federal programs and as a result Maryland has been exempted from the federal programs. When Maryland entered into the All-Payer Model Agreement with CMS effective January 1, 2014, the continuing exemption process was addressed in

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<sup>1</sup> The term "scaling" refers to the differential allocation of a pre-determined portion of base regulated hospital revenue contingent on assessment of the relative quality of hospital performance. The rewards (positive scaled amounts) or reductions (negative scaled amounts) are then applied to each hospital's revenue on a "one-time" basis (and not considered permanent revenue).

<sup>2</sup> For the Readmission Shared Savings adjustment, the HSCRC calculates a case mix adjusted readmission rate for each hospital for the base period and determines a statewide required percent reduction in readmission rates to achieve the revenue for shared savings. Current policy is posted at: <http://hscrc.maryland.gov/init-shared-savings.cfm>

the Agreement. The Agreement requires that the proportion of Maryland hospitals' revenues held at risk for quality programs be equal to or greater than the proportion of revenue that is held at risk under national Medicare programs. The objective of this requirement is two-fold: a) incentivize hospitals to deliver high quality care in support of the Triple Aim of better care, better health, and lower cost, and b) evaluate the extent to which Maryland quality programs are rewarding value as compared to those of the national Medicare program. The relevant agreement language is as follows.

*Regulated Revenue at risk: [Maryland] must ensure that the aggregate percentage of Regulated Revenue at risk for quality programs administered by the State is equal to or greater than the aggregate percentage of revenue at risk under national Medicare quality programs. Quality programs include, but are not limited to, readmissions, hospital acquired conditions, and value-based purchasing programs.*

It is important to note that under the All-Payer Model Agreement, Maryland is required to achieve specific reduction targets in total cost of hospital care, potentially preventable conditions, and readmissions in addition to its revenue at risk requirement. In an effort to meet these reduction targets, Maryland restructured its quality programs in such a way that financial incentives are established prior to the performance period in order to motivate quality improvement and sharing of best practices while holding hospitals accountable for their performance.

For FY2016 following maximum amounts of revenue at-risk were already approved by the Commission:

- QBR: 1% maximum penalty, with revenue neutral scaled rewards up to 1%.
- MHAC – 4% maximum penalty if statewide improvement target is not met; 1% maximum penalty and revenue neutral rewards up to 1% if statewide improvement target is met.
- RRIP – 0.5% positive incentive for any hospital that improves by at least 6.76%.

During the upcoming annual revenue update process for FY 2016, HSCRC staff expects that two additional quality adjustments will be applied.

- Readmissions Shared Savings Program – A savings of 0.4% total hospital revenue (approximating an average 0.6% and maximum reduction of 0.8% of inpatient revenue) based on risk adjusted readmission levels.
- PAU Reduction Program – A reduction of allowed revenue for volume increases associated with potentially avoidable utilization that had a maximum revenue reduction of 0.9% and an average reduction of 0.3% in FY 2015.

Currently staff is in discussions with CMMI regarding the methodology for comparing the Maryland aggregate amount of revenue at risk and the national Medicare aggregate amount-at-risk provided for in the Agreement. In addition to calculating maximum at risk (“potential risk”<sup>3</sup>), CMMI staff expressed a need to measure the actual revenues impacted by the programs (“realized risk”). Discussions on “realized risk” are in progress.

### **C. Assessment**

CMMI staff proposed that measurement of both the potential and realized aggregate percentage of revenue at-risk occur annually across all quality programs comparing the State fiscal year (July 1 –

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<sup>3</sup> Potential risk is defined as maximum percentage of revenue that an individual hospital stands to gain or lose based on their performance within a given quality program.

June 30) to the Federal fiscal year (October 1 – September 30). For example, Maryland’s SFY 2015 (July 2014 – June 2015) will be evaluated against CMS’ FFY 2015 (October 2014 – September 2015). Some Maryland quality programs are applied to both inpatient and outpatient revenue. For these programs, outpatient revenues at risk will be converted to an equivalent inpatient revenue base (Formula: percent of revenue at risk/percent inpatient revenue). Where applicable, both upside and downside risk will be considered.

Based upon these assumptions, Figure 1 shows the potential risk for each quality program and in aggregate for Maryland and Medicare, as well as the cumulative difference between Maryland and Medicare from 2014 to 2016. CMMI and HSCRC staff are currently discussing how to include the reduction for PAU in the Maryland program totals. For informational purposes, the tables contain two sets of totals--the first excluding the reduction for PAU and the second including the reduction for PAU. CMMI may want to separate the impact of Prevention Quality Indicators (admissions for ambulatory care sensitive conditions) from the other PAU components in evaluating the results.

**Figure 1: Maryland Versus Medicare Quality Programs’ Potential Revenue at Risk, 2014-2016**

Maryland - Potential revenue at risk

<b>% Inpatient Revenue</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>
MHAC	2%	3%	4%	4%
Readmits	0.41%	0.86%	1.36%	2.86%
QBR	0.50%	0.50%	1.00%	2%
PAU GBR	0.86%	0.86%	0.86%	0.86%
<b>Sum without PAU</b>	2.91%	4.36%	6.36%	8.86%
<b>Sum with PAU</b>	3.77%	5.22%	7.22%	9.72%

*italics are estimated numbers*

Medicare National - Potential IP revenue at risk

<b>% Inpatient Revenue</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>
HAC	0	1%	1%	1%
Readmits	2%	3%	3%	3%
VBP	1.25%	1.50%	1.75%	2%
<b>Sum</b>	3.25%	5.50%	5.75%	6.00%
Cumulative MD-US Difference				
<b>Without PAU</b>	-0.34%	-1.48%	-0.87%	1.99%
<b>With PAU</b>	0.52%	0.23%	1.70%	5.41%

Staff discussed two alternative methods to measure realized risk with the CMMI. One option is to compare Maryland and Medicare hospital average percent revenue allocated in quality programs by taking the average of all absolute value of all revenue adjustments within each program. A second option is to calculate total revenue allocated in each program and sum all absolute values as a percent of total inpatient revenue in the state. Staff calculated Maryland and Medicare percentages for FY2015

for these options (see Figure 2), revealing that Maryland is slightly above Medicare in terms of average absolute percent for FY2015 or slightly below Medicare when excluding PAU.

**Figure 2. Maryland Versus Medicare Quality Programs Realized Revenue at Risk, 2015**

Maryland: (SFY 15)

%tile (FY 15)	MHAC	Readmits	QBR	GBR PAU	Sum without PAU	Sum with PAU
100%	0.13%	-0.08%	0.28%	0.00%		
75%	0.06%	-0.59%	0.08%	-0.14%		
50%	0.05%	-0.64%	0.01%	-0.29%		
25%	0.02%	-0.72%	-0.15%	-0.44%		
0%	-1.00%	-0.86%	-0.50%	-0.86%		
FY 15 Absolute % Average	<b>0.11%</b>	<b>0.64%</b>	<b>0.14%</b>	<b>0.29%</b>	<b>0.89%</b>	<b>1.18%</b>
FY 15 Total Value Percent	<b>0.09%</b>	<b>0.67%</b>	<b>0.13%</b>	<b>0.22%</b>	<b>0.89%</b>	<b>1.11%</b>

CMS National: (FFY 15)

%tile (FY 15)	HAC	Readmits	VBP	Sum
100%	0.00%	0.00%	1.06%	
75%	0.00%	-0.06%	0.15%	
50%	0.00%	-0.31%	0.00%	
25%	0.00%	-0.77%	-0.21%	
0%	-1.00%	-3.00%	-1.37%	
FY 15 Absolute % Average	<b>0.22%</b>	<b>0.52%</b>	<b>0.24%</b>	<b>0.97%</b>

## D. Recommendations

Based upon the above assessment, current quality results for CY2014 YTD, and discussions with CMMI on our quality programs, staff’s position and rationale for revenue amounts at-risk for FY2017 are outlined below.

1. **QBR** – 2% maximum penalty. This matches Medicare’s VBP program and increases the incentive for hospitals to improve HCAHPS scores, which continue to be low compared to the Nation.
2. **MHAC** – 4% maximum penalty if statewide improvement target is not met; 1% maximum penalty and revenue neutral rewards up to 1% if statewide improvement target is met. This continues the current FY2016 at-risk revenue levels that have resulted in significant quality improvements.
3. **RRIP** – 2% scaled maximum penalty and 0.5% reward for hospitals which reduced readmission rates at or better than the minimum improvement target if the statewide

Medicare readmission target is not met; 1% scaled maximum penalty and 1% reward for hospitals which reduced readmission rates at or better than the minimum improvement target if the statewide Medicare readmission target is met. The decision to add reductions and increase potential rewards is based on staff and stakeholder concerns regarding the CY2014 YTD improvement and the fact that almost one third of hospitals have had an increase in their readmission rate.

HSCRC staff will convene meetings of the Performance Measurement and Payment Workgroups to deliberate and further refine quality-based programs' aggregate amount at risk and individual component program details prior to the January 2015 Commission meeting.





# Nurse Support Program II

Shaping the Future of the Nursing Workforce in Maryland



# Agenda

- Introduction
- Significant Outcomes
- Future Directions for the NSP II
- Recommendations for Next Cycle



# Introduction



# Nurse Support Program II (NSP II)

Created in 2005 to...

*Address the limitations of existing nursing programs in the state by increasing nursing faculty and expanding educational capacity to increase the number of qualified bedside nurses to work in Maryland*

# NSP II Components

- Competitive institutional grants
  - \$63,374,650 awarded between FY 2006 & 2015
  - Nine funding rounds
  - 26 institutions (15 community colleges and 11 universities)
- Statewide initiatives
  - \$27,997,338 provided to 950 nursing graduate students and faculty across the State



# NSP II Outcomes

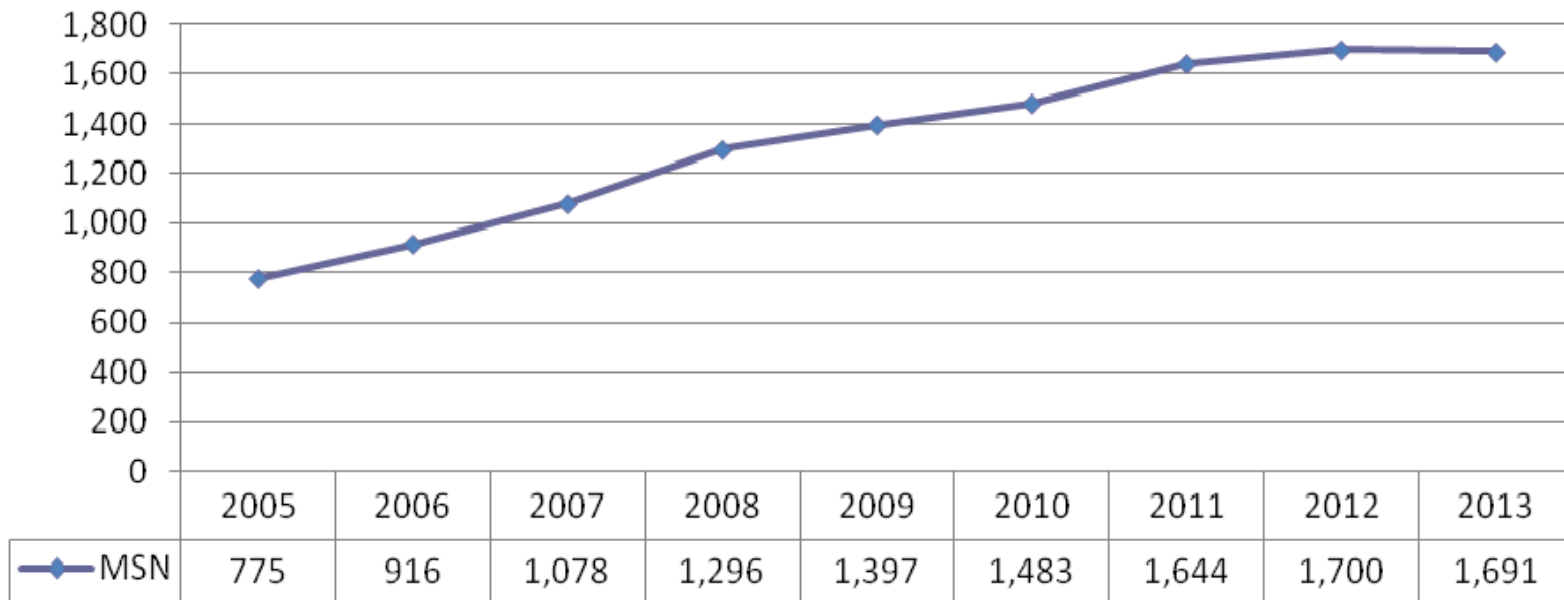


**NSP II has successfully grown the number of hospital bedside nurses and new nursing faculty.**

- Recruitment and retention of 245 new lecture and clinical faculty members at 12 universities and 7 community colleges through the *New Nursing Faculty Fellowships*
- Over 5,800 new pre-licensure nurse graduates directly tied to *Competitive Institutional Grant* program from 2006-2014

# Masters level nursing student enrollments increased by 219% between 2005 and 2013 with support from NSP II funds

**Chart 1: Masters of Science, Nursing (MSN) Enrollments  
2005 - 2013**

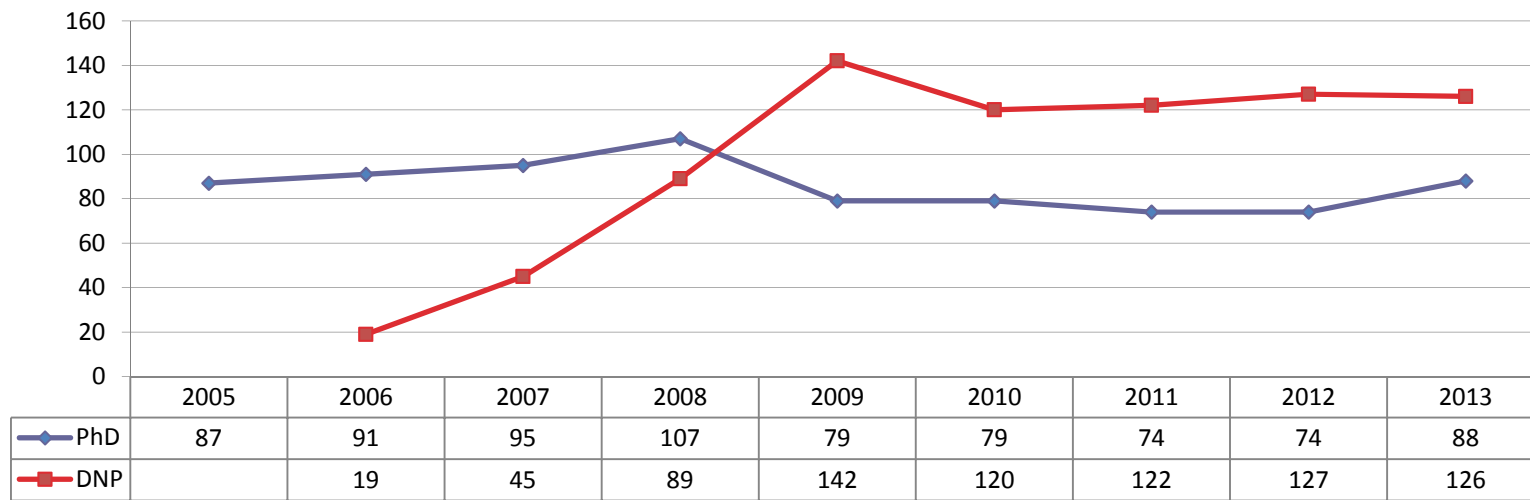


Source: Maryland Higher Education Commission Enrollment Data System



Total doctoral enrollments have increased from 87 in 2005 to 229 in 2013, representing a 245% increase.

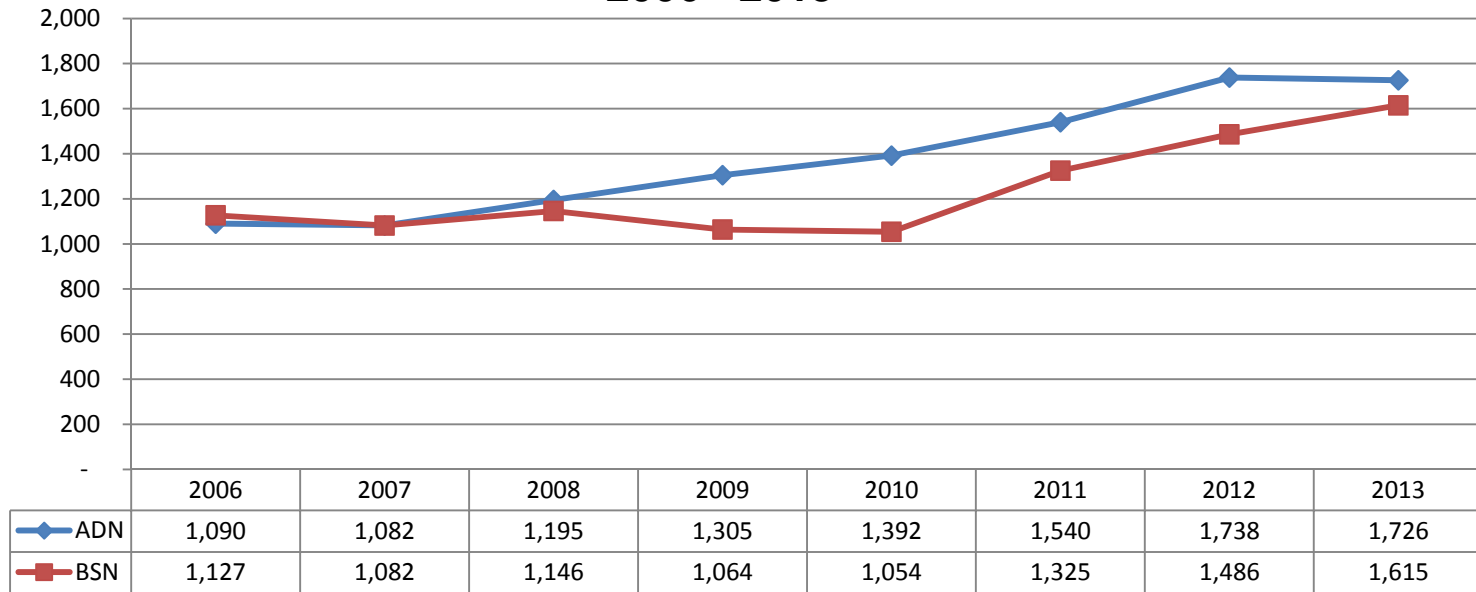
**Chart 2: Doctoral Level Nursing Enrollments (PhD, DNP)**



Source: Maryland Higher Education Commission Enrollment Data System

BSN graduates steadily increased from 1,127 graduates in 2006 to 1,615 graduates in 2013. ADN graduates steadily increased from 1,090 in 2006 to 1,726 graduates in 2013.

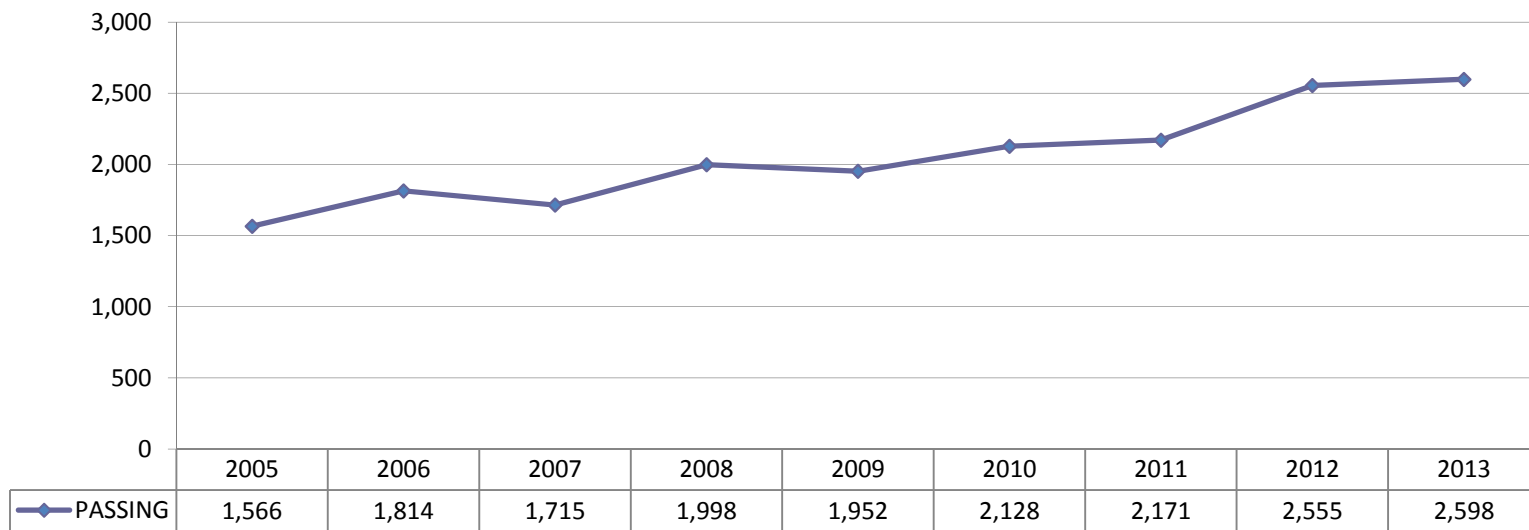
**Chart 4: Pre-Nursing Licensure Undergraduate Degrees  
2006 - 2013**



Source: Maryland Higher Education Commission Degree Information System

The number of new pre-licensure nurse graduates passing the National Council Licensure Examination for Registered Nurses (NCLEX-RN) exam on the first attempt has steadily increased from 1,566 in 2005 to 2,598 in 2013.

**Chart 5: Number of Nursing Students Passing NCLEX-RN  
(First Attempt)  
2005 - 2013**



*Source: Maryland Board of Nursing*



# Growth in MD Nursing Workforce

- Maryland Board Of Nursing data indicate an increase of 27% in the current RN workforce, much of which can be attributed to NSP II Programs.
- This growth rate is in line with recent projections that suggest the absolute size of the RN workforce will grow by 24% nationally between 2009 and 2030.

# Statewide agency nurse use – cost and FTEs has taken a dramatic upswing in 2012 and 2013

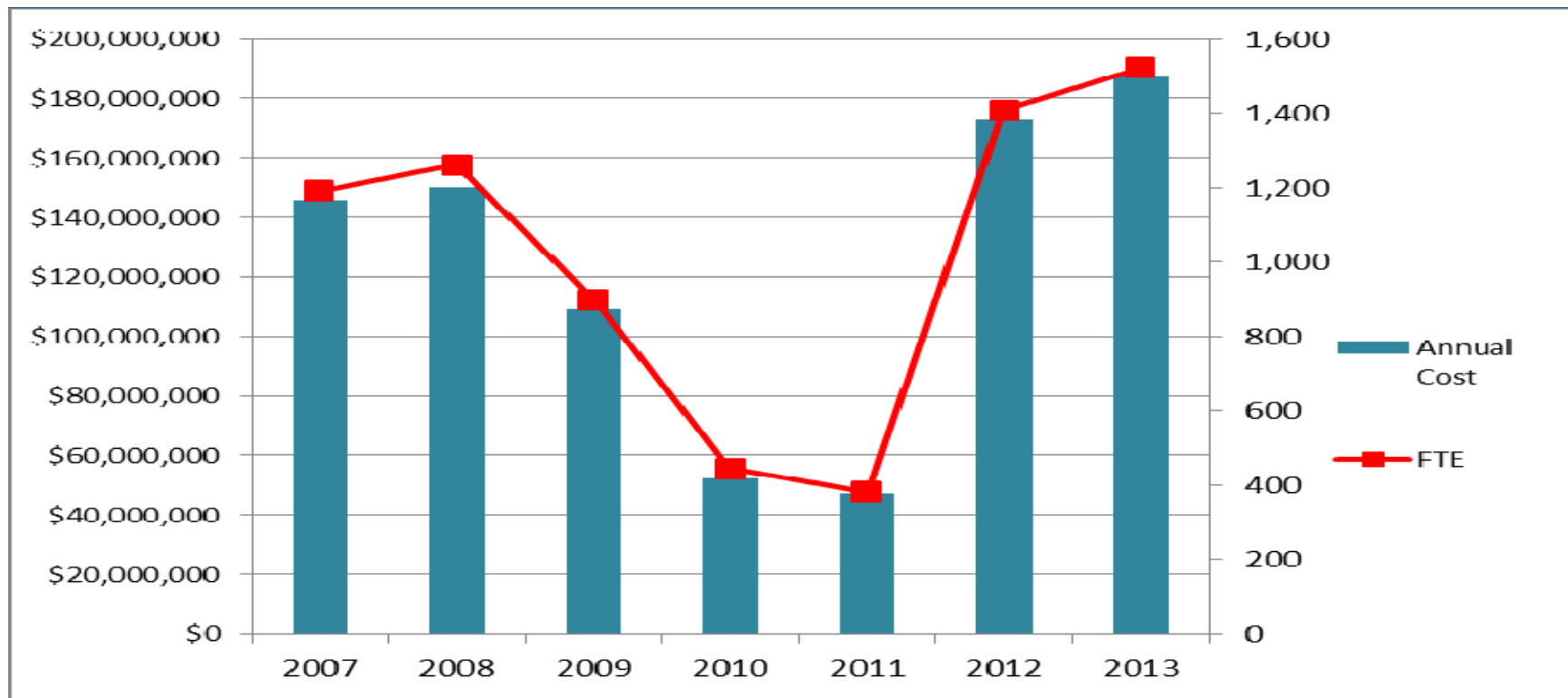


Figure 1: Statewide Agency Nurse Use - Cost and FTEs  
Source: HSCRC Wage and Salary Survey



# Future Directions For NSP II



# Evolving Issues Impacting Maryland's Hospital Nursing Workforce

- The Affordable Care Act and the New Maryland Waiver
- Changing role of nurses and hospital nurses in particular



## Evolving Issues Impacting Maryland's Hospital Nursing Workforce, Cont.

- Economy and Demographics
- Funds Supporting Nursing Programs
- Emphasis on Quality and Data




# Magnet vs. Non-Magnet Hospitals Quality

<b>Patient Experience of Care Measures CY 2012</b>	<b>Magnet Hospitals</b>	<b>Non-Magnet Hospitals</b>	<b>Difference</b>
Cleanliness of Hospital Environment	68.14%	67.27%	0.87%
Communication About Medicines	63.57%	60.46%	3.11%
Communication With Doctors*	83.14%	79.19%	3.95%
Communication With Nurses	80.14%	76.54%	3.60%
Discharge Information*	88.00%	83.70%	4.30%
Overall Rating of this Hospital*	75.14%	68.35%	6.79%
Pain Management	72.29%	70.65%	1.64%
Quietness of Hospital Environment	58.86%	57.97%	0.89%
Responsiveness of Hospital Staff	64.29%	60.54%	3.75%
Willingness to Recommend this Hospital*	76.57%	68.65%	7.92%
<b>Notes:</b>			
1. * Statistically significant at $p < .05$ .			
2. Magnet Hospitals - University of Maryland Medical Center, Mercy Medical Center, The Johns Hopkins Hospital, Dorcehster General, Sinai Hospital of MedStar Franklin Square Medical Center, Easton Memorial			



# Staff Recommendations

- 
1. Renew NSP II funding for five years, FY 2016 through FY 2020.
  2. Establish a work group to develop updated, specific goals for a competitive institutional grant program and statewide initiatives that address curricular change in response to the changing demands of nurses in the modern health landscape, such as the need for care coordination nurses.
  3. Adopt goals and metrics that address the following Institutes of Medicine (IOM) recommendations:



# IOM Recommendation For Future of Nursing, 2010 Report

- **IOM Recommendation #4:** Increase the proportion of nurses with a baccalaureate degree to 80 % of all RNs in the workforce.
- **IOM Recommendation #5:** Double the number of nurses with a doctorate by 2020.
- **IOM Recommendation #6:** Ensure that nurses engage in lifelong learning.
- **IOM Recommendation #7:** Prepare and enable nurses to lead change to advance health.



## NSP II Recommendations, cont.

4. Acquire software to manage and report on outcomes data.
5. Review current NSP II Statute in the General Assembly Education Article, Section §11-405, particularly the term “bedside nurses” to ensure that the statute meets the current needs of health care and the movement to coordinated care models.



With acknowledgement to the  
Maryland Higher Education Commission

Peg E. Daw, MSN, RN-BC  
NSP II Grant Administrator

Melinda Vann  
Director, Outreach and Grants Management



# Questions

# Nurse Support Program II (NSP II) Outcomes Evaluation FY 2006 - FY 2015 and Recommendations for Future Funding

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

December 10, 2014

This recommendation is a draft proposal. No Commission action is required at this time. Public comments should be sent to Oscar Ibarra at the above address or by e-mail at [Oscar.Ibarra@maryland.gov](mailto:Oscar.Ibarra@maryland.gov). For full consideration, comments must be received by January 2, 2015.



## EXECUTIVE SUMMARY

### **Nurse Support Program II (NSP II) Outcomes Evaluation FY 2006 – FY 2015 and Recommendations for Future Funding**

The Nurse Support Program II (NSP II) was designed to increase the number of hospital bedside nurses by mitigating barriers to nursing education enrollments and graduation. This goal is achieved by expanding academic capacity, including the number of faculty available to teach in Maryland's nursing programs while simultaneously supporting student success. The NSP II has two components, a competitive institutional grant and statewide initiatives. Nine rounds of Competitive Institutional Grant awards totaling \$63,374,650 were awarded between fiscal years 2006 and 2015. Statewide initiatives provided \$27,997,338 to 950 graduate nursing students and faculty across the State in the forms of scholarships, fellowships, or grants to help them begin or enrich careers as faculty in Maryland schools/departments of nursing. Fifteen community colleges and eleven universities across all geographic regions and types of programs participated in the NSP II. All Maryland nursing programs received one or more institutional grant awards. Notable program outcomes include:

- *New Nursing Faculty Fellowships* resulted in the recruitment and retention of 245 new faculty members (lecture and clinical) at 12 universities and 7 community colleges. Forty-four percent (44%) were from underrepresented groups in nursing. The retention of new full-time faculty is 88%.
- Bachelor degree program (BSN) enrollments were 4,086 in 2005 rising to 6,832 in 2013, a 67% increase. Associate degree (ADN) enrollments rose 27% from 9,507 in 2005 to 12,971 in 2013 with assistance from NSP II programs.
- BSN graduates steadily increased from 1,127 graduates in 2006 to 1,615 graduates in 2013. ADN graduates steadily increased from 1,090 in 2006 to 1,726 graduates in 2013.
- Over 5,800 new pre-licensure nurse graduates can be directly tied to competitive institutional grant program outcomes from 2006-2014.
- The number of new pre-licensure nurse graduates passing the National Council Licensure Examination for Registered Nurses (NCLEX-RN) exam on the first attempt has steadily increased from 1,566 in 2005 to 2,598 in 2013. Just as important, the first attempt pass rates have remained consistent even as access to programs increased, thereby indicating

maintenance and improvements in Maryland's nursing education programs during a time of unprecedented expansion.

- The number of active licensed nurses increased from an average of 58,408 from 2005 to 2007 to an average of 74,497 from 2008 to 2012. MBON data indicate an increase of 27% in the RN workforce, much of which can be attributed to NSP II Programs. This growth rate is in line with recent projections that suggest the absolute size of the RN workforce will grow by 24% nationally between 2009 and 2030. (Auerbach, et al., 2011)

The NSP II has been successful in increasing the number of available hospital bedside nurses. However, there are indicators that suggest the nursing workforce shortage in Maryland is not fully resolved. Current issues impacting the State's nursing workforce include predicted nurse retirements – especially those delayed by an economic recession that is now correcting changes in patient care related to the State's Medicare waiver and the federal Affordable Care Act, hospital migration to magnet status which is associated with better patient outcomes, and changes in hospital health care delivery to a care coordination model. Staff recommends that the Commission consider five actions regarding the future direction of NSP II.

1. Renew NSP II funding for five years, FY 2016 through FY 2020.
2. Establish a work group to develop updated, specific goals for a competitive institutional grant program and statewide initiatives.
3. Adopt goals and metrics that address the following Institutes of Medicine (IOM) recommendations: #4, #5, #6, & #7 (Refer to the Recommendations Section for full detail on the IOM recommendations).
4. Purchase software to manage and report on outcomes data.
5. Review current NSP II statute in the General Assembly Education Article, Section §11-405, particularly the term "bedside nurses" to ensure that the statute meets the current needs of health care and the movement to coordinated care models.

## **EXECUTIVE BRIEF**

### **Nurse Support Program II (NSP II) Outcomes Evaluation FY 2006 – 2015 and Recommendations for Future Funding**

#### **INTRODUCTION**

The HSCRC established the Nurse Support Program II (NSP II) on May 4, 2005. The NSP II, administered by the Maryland Higher Education Commission (MHEC) in collaboration with the HSCRC, is complementary to the Nurse Support Program I (NSP I), a hospital based program. The NSP II is funded through pooled assessments totaling up to 0.1% of hospital regulated gross patient revenue over a ten year period ending June 30, 2015. The NSP II employs an effective three-prong strategy for increasing the number of nurses in the State with the ultimate goal of reducing hospital costs. These goals are achieved by increasing the number of nursing lecture and clinical faculty, supporting schools and departments of nursing in expanding academic capacity and curriculum, and providing support to enhance nursing enrollments and graduation. This Executive Brief describes program outcomes including program impact on the State's nursing workforce. Findings related to nurse supply and demand, the State's academic capacity to increase enrollments and graduation in nursing programs, entry to practice, and the preparation of teaching and clinical faculty are presented. An examination of current and future nurse workforce issues, post NSP II, is presented as well. The Executive Brief concludes with recommendations for the future of the program.

#### ***Program Inception and Purpose***

Maryland was one of five states to be granted a Medicare waiver in 1977 which exempted the State from traditional Medicare payments (codified in Section 1814 (b) of the Social Security Act). The HSCRC was established as an independent state agency with full rate setting authority over all general acute care hospitals in Maryland. The HSCRC has the authority to adapt the rate system to changing dynamics within health care. As such, it provides a flexible and stable funding source for the NSP I for hospitals and NSP II for Schools/Departments of Nursing, as part of its larger mission to control costs and ensure the quality of health services. Today, Maryland is the only state that continues to set its own hospital rates for all payers.

In 2003, the nursing shortage in Maryland was worsening despite the efforts of the NSP I hospital based programs. Vacancy rates exceeded 15%, and the cost of agency nurses was over

\$144 million (Heller & Sweeney, 2003). There were not enough new nursing graduates to meet hospital workforce demand. Leaders from hospitals and educational institutions realized that a shortage of nursing faculty was restricting the capacity of schools to admit and educate more nurses to meet market demand. A group of stakeholders interested in statewide solutions helped establish NSP II to satisfy the needs of hospitals for bedside nurses through education focused programs that would grow capacity by increasing the number of nursing faculty and nursing students.

In 2006, the Maryland Higher Education Commission (MHEC) and the Maryland Board of Nursing (MBON) completed *The Maryland Nursing Program Capacity Study* requested by Senate Bill 511 (Chapter 487, Acts of 2005). This study built upon the work of the Center for Health Workforce Development and the Statewide Commission on Nursing, which was concluded in 2006. The Nurse Support Program II was established in State statute (Annotated Code of Maryland, Education Article §11-405, Nurse Support Program Assistance Fund) and funded through HSCRC rates. A Memorandum of Agreement between the HSCRC and the Maryland Higher Education Commission was established, whereby MHEC was charged to administer the NSP II programs under the auspices of the HSCRC. The MOU identified the purposes of the NSP II as: 1) increasing the number of bedside nurses in Maryland hospitals; and 2) expanding the capacity of Maryland nursing schools to produce qualified nurses to work in Maryland. These goals were achieved through a competitive institutional grant program and statewide initiatives. Statewide initiatives include activities supporting students and faculty while the competitive institutional grant program increased capacity of the nursing programs (HSCRC and MHEC MOU, 2006). Creating a diverse nursing faculty and workforce also are goals for the program.

### ***Competitive Institutional Grant Program and Statewide Initiatives***

Two types of programs are supported by the NSP II. These include the Competitive Institutional Grant program and Statewide Initiatives. A brief description of each type of program follows.

*Competitive Institutional Grant Program.* Competitive institutional grants are designed to increase the structural capacity of Maryland nursing schools through shared resources, innovative educational designs, and streamlined processes to produce more nurse faculty, and nursing undergraduate and graduate nurses. Grants support activities such as the establishment

of new degree programs, curriculum enhancement and redesign, student retention initiatives, and simulation and other productivity enhancing instructional technologies. The grants also contribute to the creation of a more diverse nursing faculty and workforce. Many grant projects prepare more graduate level nurses qualified to serve as lecturers and/or clinical faculty at Maryland's higher education institutions.

*Statewide Initiatives.* Statewide initiatives include the *New Nurse Faculty Fellowships* (NNFF), the *Nurse Educator Doctoral Grants for Practice and Dissertation Research* (NEDG), and the *Hal and Jo Cohen Graduate Nursing Faculty Scholarship and Living Expenses Grant* (GNF/LEG). The NNFF provides funding for newly hired nursing faculty to support their research and teaching. Funds assist faculty with the work necessary to gain tenure, and support faculty retention. The NEDG provides funds to support doctoral nursing students during their critical final phase of graduate study — the dissertation or capstone project. Research suggests that this is a critical retention junction as many students drop out at this point. The NEDG, a relatively new program, appears to positively impact retention and completion. The Hal and Jo Cohen graduate financial aid programs provide powerful incentives for currently practicing nurses and others to pursue graduate level education and faculty positions in both classroom and/or clinical settings.

### ***Program Sunset and Evaluation Methodology***

The last round of funding that supports the NSP II ends in FY 2015. At the request of the HSCRC, MHEC and HSCRC staff conducted a comprehensive program review. Assistance was provided by a Nursing Faculty Advisory Group, representatives of the Maryland Hospital Association, and NSP I Nurse Residency leaders with the Maryland Organization of Nurse Executives. NSP II competitive institutional grant recipients were instrumental in the collection of project outcomes data and collaborated with nurse executive leaders on hospital based measures.

Data were collected and compiled for all NSP II funded projects for all years of activity for which data were available. Excel and SPSS were used to compile and analyze the data. Both quantitative and qualitative data analysis was applied, most notably descriptive statistics, case study, and thematic analysis. Outcomes were compared to project goals. A summary of important outcomes is discussed in the following section. Findings on the most successful strategies utilized by NSP II and suggested revisions for improvement are included in the review of activities and

outcomes.

## **NSP II PROGRAM EVALUATION AND OUTCOMES 2006-2014**

### ***Competitive Institutional Grants Overview***

Nine rounds of institutional competitive grants were awarded between July 1, 2005 and June 30, 2014, totaling \$63,374,650. A total of 109 institutional multi-year grants were awarded through a competitive review process. Fifteen community colleges and eleven universities received funding. Grant recipients included schools or departments of nursing at public universities including the State's four historically black institutions, independent colleges and universities, and community colleges. The distribution of awards was geographically diverse with three institutions in Western Maryland, two institutions on the Eastern Shore, three institutions in Northern Maryland, and one institution in Southern Maryland. The remaining institutions are located in the central region of the State and Baltimore City. Grant recipients received funds in installments over the life of the grant contingent upon adequate yearly progress. Forty-one (41) projects have successfully concluded allowing for a detailed analysis of the strategies used by the most successful awardees. Sixty-eight (68) awards remain open, some with annual payments extending into FY 2017 (with funds accrued through FY 2015). While these projects have not yet concluded, annual outcomes to date are included in the data analysis.

### ***Statewide Initiatives Overview***

There were eight funding cycles for the NFFF and GNF/LEG. There were two funding cycles for the NEDG. A total of \$27,997,338 has been disbursed to date through these programs. Nurses either committed to become nursing faculty through attainment of graduate education, advanced their careers (tenure-track) as faculty through earning doctoral education, or joined an institution as a new faculty member. A description of each program within the Statewide Initiatives follows.

*New Nursing Faculty Fellowships (NFFF).* The Nurse Support Program II provides funding for New Nursing Faculty Fellowships to newly hired faculty. These fellowships assisted Maryland nursing programs in recruiting and retaining new nursing faculty to produce the additional nursing graduates required by Maryland's hospitals. Since FY 2007, 245 new faculty members have been recruited through this program and received a total \$4,105,000. Each fellowship is funded for three years. The retention rate for these faculty is currently 88%. Overall, 44% (n=108) were from underrepresented groups in nursing (ethnic and racial minorities and males). The participating Academic Deans and Directors unequivocally stated that this program was an effective tool that

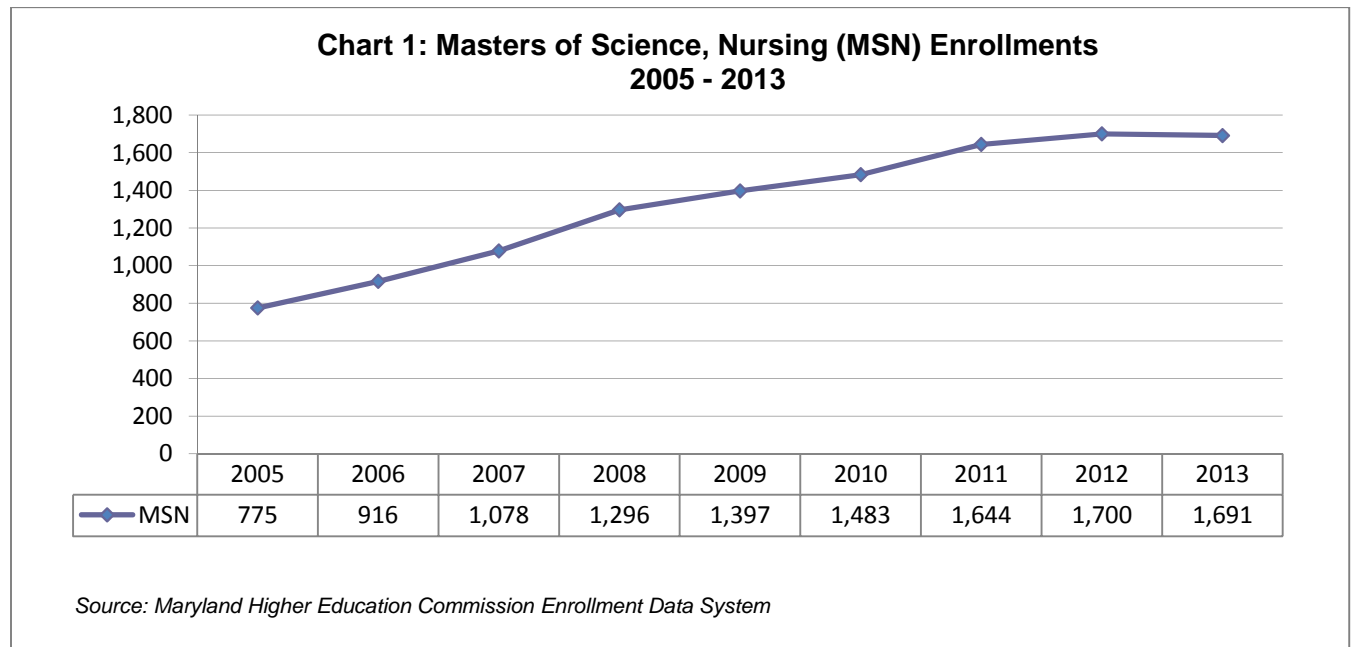
helped them recruit and retain new highly qualified professors. The NNFF recipients were allowed to use funds to pay down student loans, attend and present at professional conferences, conduct research, develop publications for refereed journals (a tenure-track requirement), and other professional development activities.

*Nurse Educator Doctoral Grants for Practice and Dissertation Research (NEDG).* The NEDG provides grants to doctoral students, some of whom may be serving as nursing instructors or assistant professors, to complete the final phase of their doctoral program -- the dissertation (Doctorate of Philosophy, PhD) or capstone (Doctorate of Nursing Practice, DNP). Funds may be used to offset research, tuition, and other educational costs related to expediting degree completion. Since inception in 2012, at the request of the HSCRC, there have been 26 awards totaling \$630,000. After doctoral completion, the newly conferred PhDs and DNPs provide the abstracts and citations of their dissertations, capstone project papers, and any published work or other scholarly projects. Many doctoral projects are focused on educational issues in nursing: e.g., simulation, medication errors, student retention, faculty shortage and teaching modalities that inform best practices in nursing education and clinical practice.

*Hal and Jo Cohen Graduate Nursing Faculty Scholarship and Living Expenses Grant (GNF/LEG).* The GNF and LEG supported registered nurses to enter graduate nursing programs in Maryland and to complete the coursework to be qualified as nurse faculty. The scholarship is contingent upon a service obligation to teach nursing in nursing programs in Maryland. Recipients who are unable to meet the service obligation must repay the GNF through a bond repayment plan. The scholarship supports Masters and Doctoral degree enrollment, as well as a post-graduate teaching certificate. Since FY 2007, a total of 679 nurses have been awarded \$19,068,978 in scholarships for tuition and living expense grants. Most of these recipients were nurses pursuing Masters Degrees (a pre-requisite for doctoral level study). Nine recipients have completed their teaching service obligation; 159 are working as Maryland nursing faculty in fulfillment of the service obligation; 156 recent graduates are seeking teaching positions, 30 are in repayment and 10 have completed repayment. The remaining students are enrolled in graduate degree programs (Masters or Doctoral level).

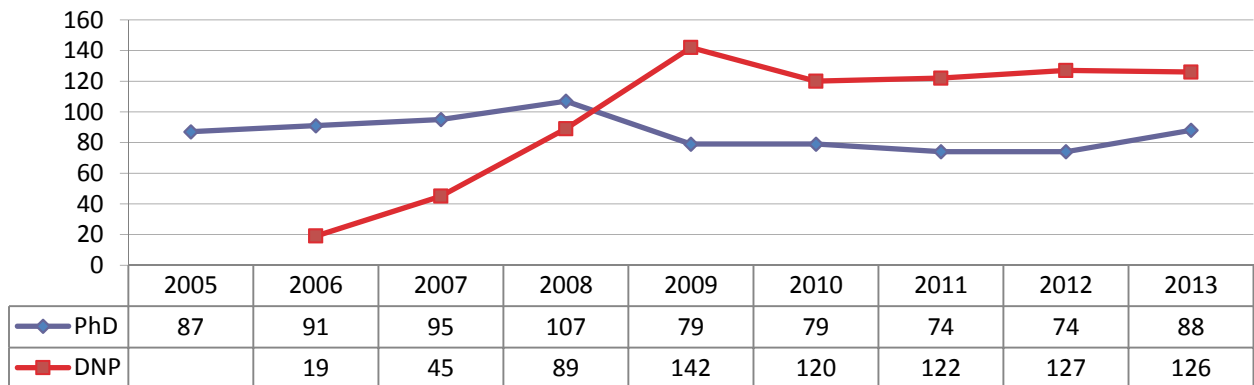
***Post-Nursing Licensure Masters and Doctoral Degree Enrollments***

The most salient goal of the NSP II program is to increase the academic capacity of nursing programs in order to produce more qualified nurses. One way this goal is being achieved is by "growing our own" nursing faculty. The competitive institutional grant and statewide initiatives support projects that expand the pool of nurses and nursing students with the graduate credentials necessary to become faculty members. These programs also provide incentives to pursue teaching versus practice given that nursing practice commands much higher salaries than college-level teaching. Four new Masters degree programs and four new Doctorate of Nursing Practice (DNP) degree programs are directly attributable to the NSP II. These new programs have enrolled 1,445 new Masters and 526 new Doctoral students since opening for business from 2007-2012. Simultaneously, enrollments in existing programs were significantly expanded. Graduate nursing student enrollments have increased by 219% between 2005 and 2013 with support from NSP II funds. Total doctoral enrollments have increased from 87 in 2005 to 229 in 2013, representing a 245% increase. In addition, many students completed teaching certificates specifically designed to prepare nursing educators developed through the support of NSP II. Refer to the Charts 1 and 2 below.





**Chart 2: Doctoral Level Nursing Enrollments (PhD, DNP)**



Source: Maryland Higher Education Commission Enrollment Data System

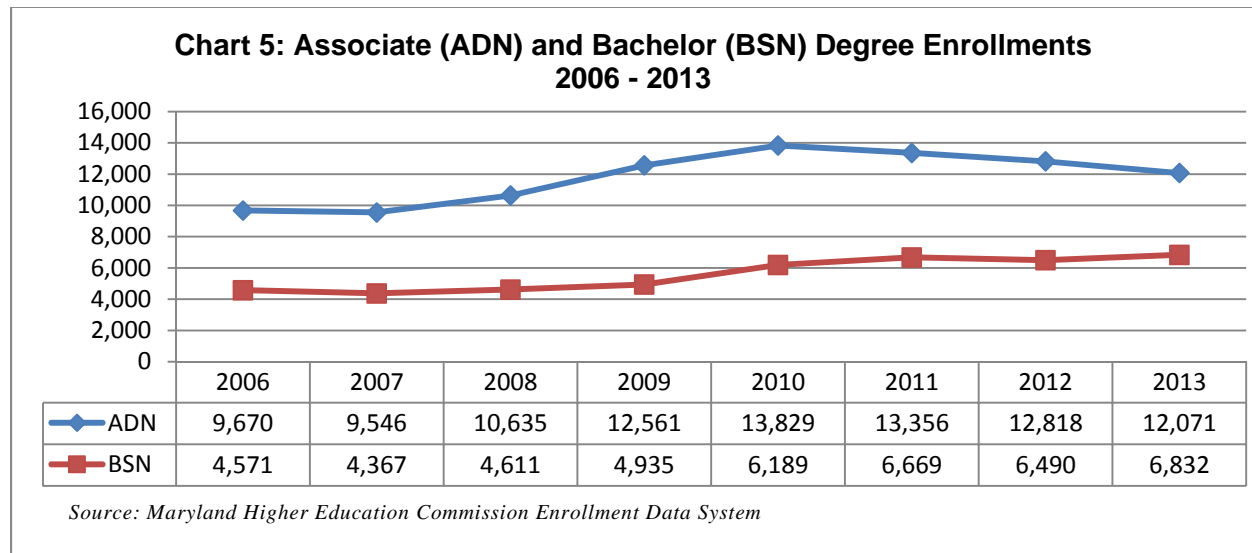
***Post-Nursing Licensure Masters and Doctoral Degree Production***

Graduates from Masters’ programs have increased by 219% between 2005 and 2013 with support from NSP II funds. Doctoral degree conferment has increased as well. Since the first graduates in 2006, 621 new Masters and 203 new Doctoral degrees can be directly attributed to the grant from measurable outcomes reported by project directors on annual and final reports. In addition, 38 Nurse Educator Teaching Certificates were completed at post-graduate programs.

***NSP II Impact on Enrollments in Undergraduate Nursing Programs***

The NSP II strives to increase student enrollments and degree production in all levels of undergraduate nursing programs - both two and four-year degrees. By increasing the number of nursing faculty through the production of graduate level preparation, undergraduate programs can likewise grow. Associate Degree Nursing (ADN) program enrollments were 9,670 in 2006 compared to 12,071 in 2013 (45% increase). ADN enrollments leveled off after 2010 due to increasing emphasis on student retention in the ADN program, changes to the federal Pell Grant program, and increasing demand for Bachelor of Science in Nursing (BSN) prepared nurses as hospitals sought Magnet status. Refer to the table below. New graduate RNs complete either ADN or BSN programs prior to the licensing examination. After passing licensure, the ADN RNs may continue to BSN completion. All BSN nurses may then continue in post-graduate Masters or Doctoral programs. There is a growing demand for seamless progression from the ADN to the BSN. Recently, NSP II-funded new models for dual

enrollment are increasing the RN to BSN options available to current registered nurses holding with two-year degrees. During the same time period, enrollments in baccalaureate nursing program increased from 4,571 in 2006 to 6,832 in 2013 (67%). between 2005 through 2013. After a brief leveling between 2011 and 2012, BSN student enrollments appear to be increasing again.

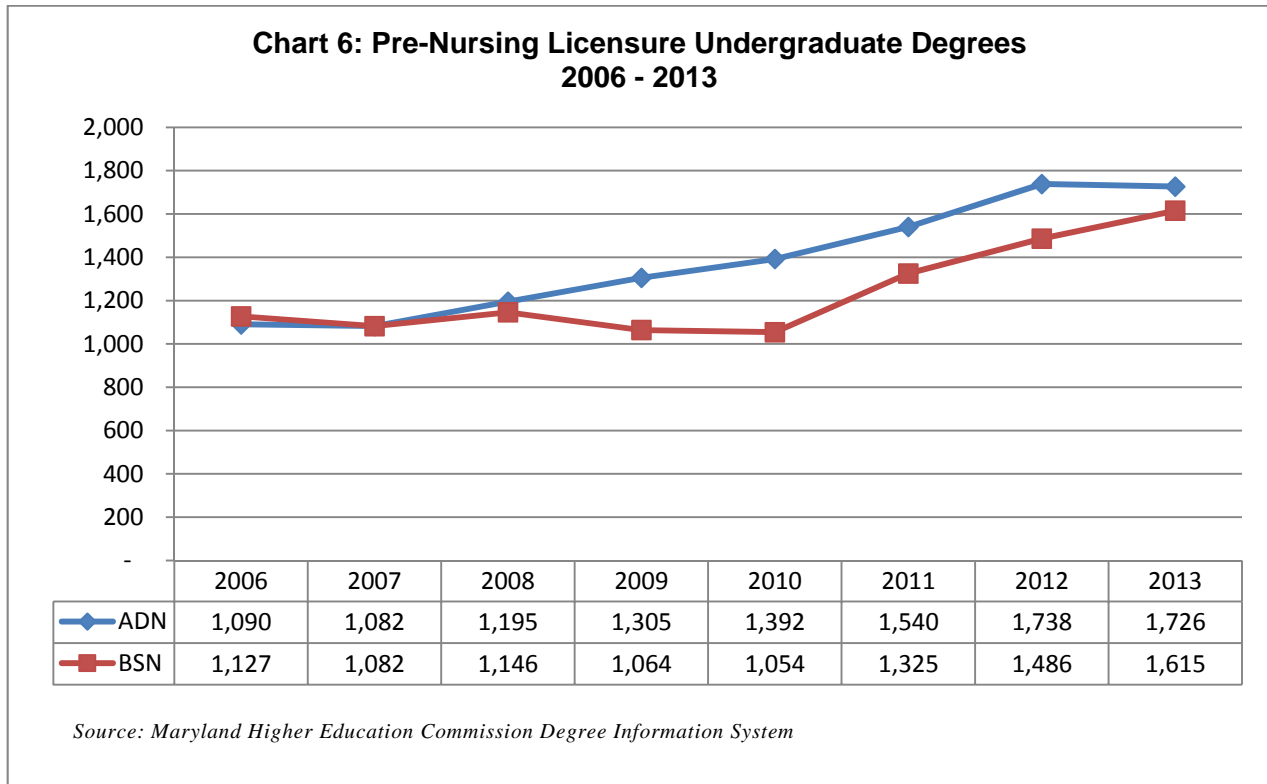


### ***Degree Production (ADN and BSN)***

In 2013, 1,726 ADNs were awarded compared to 1,090 in 2006 (58% increase). Furthermore, ADNs increased steadily each year from 2007 forward as the NSP II program implementations gained strength (Chart 6). These same associate degree trained nurses are able to take advantage of ADN to BSN programs supported by NSP II funds. Similarly, in 2013, there were 1,615 BSN degrees awarded compared to 1,127 in 2006. This is a 43% increase. BSN production increased most dramatically in 2011, 2012, and 2013 reflecting new students who entered BSN programs in 2008 or later, as NSP II supported programs were fully ramped up.

While some undergraduate nursing degree increase is attributable to natural growth, data provided by NSP II competitive institutional grant project directors suggest that ***over 5,800 or 27% of all undergraduate nursing degrees produced between 2006-2013 are directly attributable to the NSP II competitive institutional grant program focused on student retention initiative, redesigned curriculum options, and new programs.*** This number does not include the number of new students admitted and graduated due to an

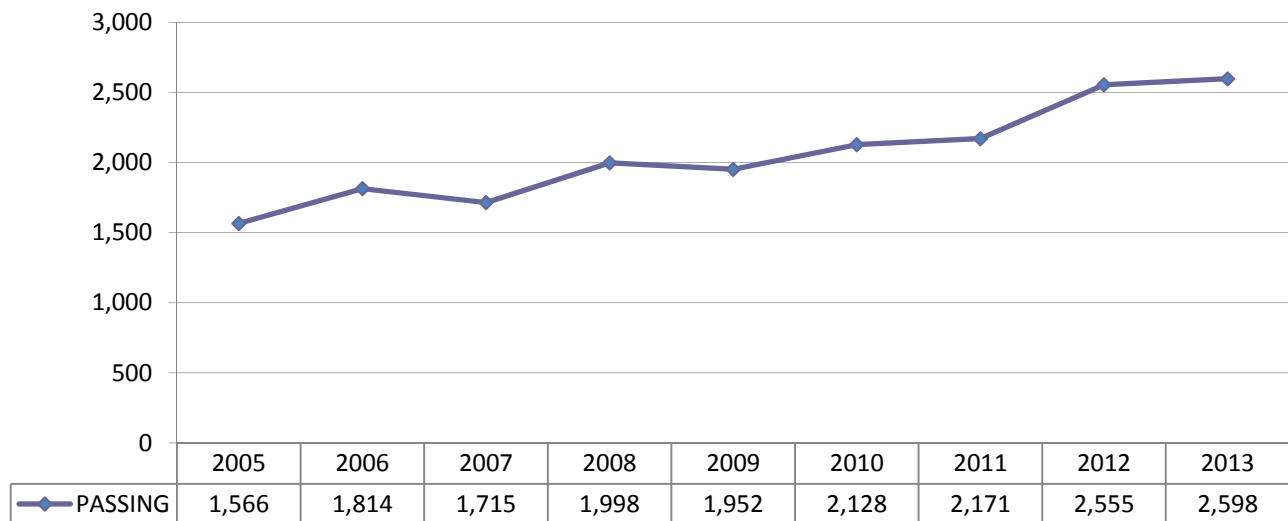
increase in the number of faculty recruited through statewide initiatives. In addition, a new NSP II funded RN (ADN) to BSN program in Western Maryland and expansion of similar existing programs produced 506 new BSNs who were formerly RNs with two-year degree credentials.



### ***NCLEX Pass Rates***

The number of Maryland nursing graduates passing the National Council Licensure Examination (NCLEX) exams on the first attempt has steadily increased over the course of the NSP II Program from a baseline of 1,566 in 2005 to 2,598 in 2013 (Chart 7). This represents a 66% increase in the number of newly licensed RNs passing licensure on the first attempt across the State. The percentage of students passing the NCLEX in one or more attempts was 87% in 2005 and 86% in 2013 suggesting that even as access to nursing programs expanded, quality as demonstrated by the NCLEX pass rate has been reasonably maintained.

**Chart 7: Number of Nursing Students Passing NCLEX-RN (First Attempt)  
2005 - 2013**



*Source: Maryland Board of Nursing*

***NSP II Impact the Nursing Workforce - Diversity, Nurse Vacancy Rates, Agency Nurse Use and Cost***

The Maryland nursing workforce shortage has been mitigated by NSP II educational interventions targeting institutions and individuals. At the institutional level, competitive grants increased educational capacity of schools to enroll and graduate new nurses. At the individual level, financial aid and fellowships were awarded to nurses who committed to become and/or be retained as nursing faculty in Maryland.

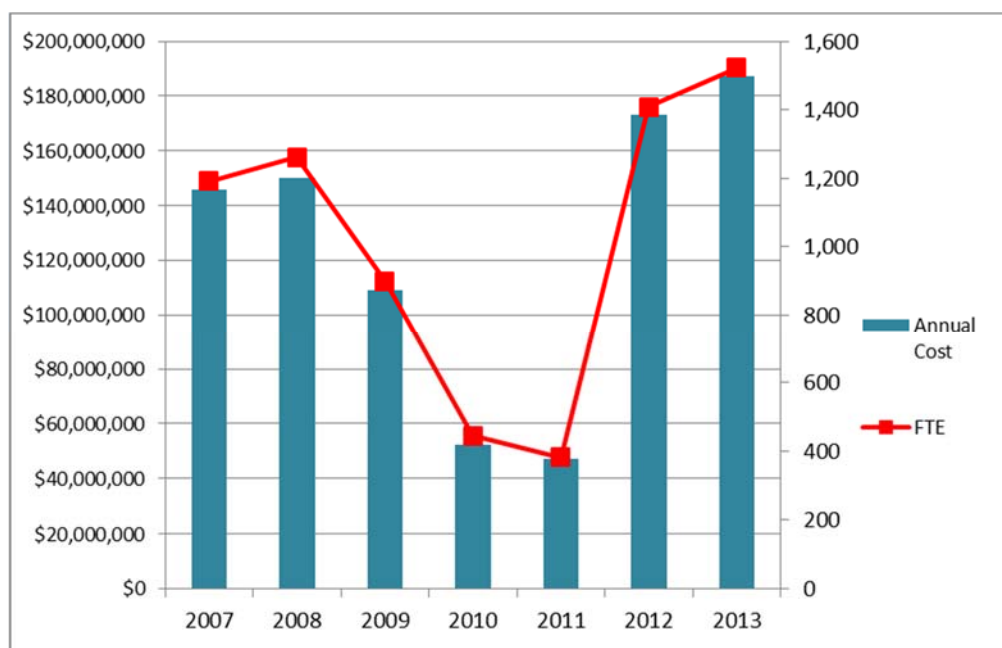
*Diversity.* In addition to increasing the number of nurses, NSP II programs helped to educate a more diverse cadre of nurses by engaging Maryland's historically black colleges and universities (HBCU) and urban and rural serving community colleges. While MHEC and the HSCRC have not been able to collect needed demographic workforce data, it is well understood that Maryland's HBCUs and community colleges serve a highly diverse student body by race/ethnicity, age and socio-economic status.

The NSP II has also impacted hospital nurse vacancy rates, agency nurse use, and costs. A more detailed discussion of the impact on vacancy rates, agency nurse use and costs follows.

*Nurse Vacancy Rates.* In 2002, prior to NSP II, the Maryland hospital nurse vacancy rate was 15.6%. By 2007, shortly after NSP II was implemented, the Maryland hospital nurse vacancy rate had dropped to 10.2%. In 2011, it dropped to 5.6% and hovered around 5.3% through 2012. To compensate for nurse vacancies, hospitals were forced to use costly strategies such as overtime, agency staff, and travel nurses. These strategies also had the potential to negatively affect quality, safety, the patient experience, physician satisfaction, and hospital employee job satisfaction. Data on Maryland agency nurse use shows a sharp upward trend, which suggests that nurse vacancy rates are on the rise again (see chart at the end of this section).

*Agency Nurse Use.* The NSP II appears to have had some positive impact on the costly use of agency nurses by Maryland hospitals. Agency nurse use declined sharply between 2008 and 2011 but is currently on the rise (Figure 1). Agency nurse use increases costs to hospitals struggling to permanently fill positions and meet patient service levels. Current agency nurse rates range from \$55 to \$78 per hour depending on area of practice, contract status and schedule. This is in sharp contrast to the average staff nurse's base salary of approximately \$36 to \$40 per hour. Maryland hospitals vary in full time nurses and nursing hours. In 2012, there were 22,365 RNs employed at 67 hospitals (MHA, 2014). Using an average of 334 RNs, the difference in the average cost of nurse hours between agency RNs and full time employee RNs at an average hospital could be \$16,673,280. In the three years since the NSP I evaluation report, agency nurse use has risen substantially, due in part to hospital's efforts to adjust to the new Medicare waiver requirement. As nurses left positions, hospitals were more selective in hiring replacement nurses. Furthermore, hospital nurse leaders report hiring is increasing this year, after the contractions of services and changes within the industry in the last two years (HSCRC & MHEC meeting, 10/27/14).

**Figure 1: Statewide Agency Nurse Use - Cost and FTEs**



Source: HSCRC Wage and Salary Survey

## **FUTURE DIRECTIONS FOR THE NSP II**

### ***Evolving Issues Impacting Maryland's Hospital Nursing Workforce***

In considering Maryland's hospital nursing workforce needs and implications for the possible renewal and revision of the NSP II program, several changes in the healthcare landscape are noted. These include changes in the federal healthcare programs, best practice recommendations from the Institutes of Medicine, the changing roles of nurses, and the increased emphasis on quality and patient satisfaction. A discussion of the impact of these changes, the projected job openings through 2022, potential nursing shortages, and changing demographics follow.

*Federal Programs.* In 2010, the federal *Affordable Care Act (ACA)* was signed into law. It represents the most significant change to national health care laws since the 1965 enactment of Medicare and Medicaid programs. The ACA currently provides private insurance coverage to 67,000 Marylanders who previously lacked health insurance; however, this number is expected to grow. This estimate also does not include newly eligible Medicaid recipients from the expanded income requirements or the estimated 90,000 primary adult care eligible citizens who were not covered for non-emergent hospital services before the ACA was enacted. The ACA will

increase demand for nurses as it strives to build a health care system that meets the national “Triple Aim” for healthcare – better health, better care, and lower cost.

The HSCRC collaborated with the Centers for Medicare and Medicaid Services to modernize the State’s Medicare waiver in January 2014. Hospitals now operate on a value of services model rather than on a volume model. Rates are tied to improvements in the health care quality, population health, and per-capita cost growth. As a result, unnecessary and potentially avoidable services and procedures that formerly brought revenue now increase cost; the preventative services and primary care now become a key reducing avoidable utilization. This means developing strategies that help individuals stay healthy, reduce hospital readmissions, and prevent avoidable adverse outcomes, all essential to the ultimate success of the new All-payer model. Hospital-based nurses providing interventions to improve coordinated recovery and transition to home can make dramatic differences in care and at the same time reduce cost. As the largest group of health professionals, nurses have many opportunities to influence patient outcomes. This shift also requires new training in the form of continuing education, nurse preparation program curriculum, and nurse educator knowledge.

*IOM Recommendations for Nursing.* In 2010, *The Future of Nursing: Leading Change, Advancing Health* report was released by the Institutes of Medicine (IOM) in partnership with the Robert Wood Johnson Foundation. The report articulated the importance of nurses in providing safe, quality, accessible, affordable, and patient-centered care, and offered eight recommendations for action by states. Nursing leaders in Maryland formed the Maryland Action Coalition to promote the implementation of the recommendations as a blueprint for the nursing profession. Since the IOM (2010) report recommended increasing the number of BSN prepared nurses to 80% of all RNs by 2020, it has taken three years to improve from 50% to 55%. Beginning in 2014, hospitals seeking magnet hospital recognition must have an action plan and demonstrate progress toward achieving the 80% of nursing staff with BSN goal. The push behind more highly educated nurses is based on recent studies that suggest higher levels of nurse education are linked to better patient outcomes. For example, one study showed a 10% increase in the BSN workforce proportion reduced the odds of patient mortality by 10.9% (Yakusheva, et al., 2014).

*Changing Role of Nurses and Hospital Nurses in Particular.* Hospital nurses are at the forefront of moving from practices based purely on acute care admission frameworks towards

models based on health promotion and population health. Hospitals have or are restructuring to provide for “whole person” health care delivery. Continuity of care across acute and chronic conditions can be managed through a partnership among providers, payers and patients/families. The care coordination models demonstrate improved outcomes in the acute care inpatient settings when RN care coordinators, primary care physicians, other members of the health team and patient/family interact openly and participate in decision-making. Collaboration between patient and provider partners leads to better self-care management, improved functional health, and reduced readmissions. Nurses are central to care coordination for their clinical expertise, critical thinking, and organizational skills (Hajewski & Shirey, 2014). Nurses are positioned to coordinate transitions to home because they are the largest group of care providers; they spend the most time interacting with patients; and they are integral to safe discharge planning and to identifying specific factors that may require attention within the patient’s home environment.

*Emphasis on Quality and Data.* The Department of Health and Human Services (DHHS, 2014) reported on 2011-2012 data from the National Database of Nursing Quality Indicators (NDNQI) on the nurse’s impact on patients. Through quality focused initiatives, nurses saved \$4 billion in health care spending, decreased the hospital acquired conditions by 9%, reduced readmissions for Medicare patients by 8%, prevented 560,000 patient injuries and saved 15,000 lives. Maryland is one of 14 states that increased the number of data points collected to be reported nationally. The nurse sensitive quality measures link nursing services with quality of care, patient outcomes and cost of care.

The Magnet designation through the American Nurses Credentialing Center (ANCC) recognizes hospitals for nursing excellence. Hospitals’ commitment to staffing with highly trained nurses and putting them in leadership positions, thereby allowing them to have substantial input into patient safety issues is a benchmark for consumers seeking care. Patient experience as measured by Maryland HCAHPS scores for CY 2012 was compared among Magnet designated and non-Magnet designated acute care hospitals. As seen below, Magnet designated hospitals' HCAHPS scores were consistently higher than non-Magnet designated hospitals. For 2012, Magnet designated hospitals' scores ranged from 1.64% to 7.92% higher (Table 1). Statistically significant differences were found for overall hospital rating, willingness to recommend the hospital and discharge instruction, indicating patients had a better experience at a hospital with Magnet designation.



**Table 1: CY 2012 HCAHPS Scores - Magnet vs Non-Magnet Hospitals**

Patient Experience of Care Measures CY 2012	Magnet Hospitals	Non-Magnet Hospitals	Difference
Cleanliness of Hospital Environment	68.14%	67.27%	0.87%
Communication About Medicines	63.57%	60.46%	3.11%
Communication With Doctors*	83.14%	79.19%	3.95%
Communication With Nurses	80.14%	76.54%	3.60%
Discharge Information*	88.00%	83.70%	4.30%
Overall Rating of this Hospital*	75.14%	68.35%	6.79%
Pain Management	72.29%	70.65%	1.64%
Quietness of Hospital Environment	58.86%	57.97%	0.89%
Responsiveness of Hospital Staff	64.29%	60.54%	3.75%
Willingness to Recommend this Hospital*	76.57%	68.65%	7.92%
Notes:			
1. * Statistically significant at p<.05.			
2. Magnet Hospitals - University of Maryland Medical Center, Mercy Medical Center, The Johns Hopkins Hospital, Dorchester General, Sinai Hospital of MedStar Franklin Square Medical Center, Easton Memorial			

*Funds Supporting Nursing Programs.* The Nurse Support Program I, implemented in 2001, was designed to support hospital based nursing workforce initiatives for acute care nurses and serves as a companion and complementary program to the NSP II. Due to program success in creating hospital savings, the HSCRC renewed the NSP I in June of 2012 for five years.

*Economy and Demographics.* The recession of 2008 prompted nurses to delay retirements, increase hours of work, and/or return to work. As a result, hospitals and other employers experienced reduced turnover in nursing staff (Auerbach, et al., 2013). Nursing vacancy rates trended downwards and have held steady around 5% (MHA, 2012). Retiring baby boomers, rising chronicity, accelerating acuity, and the implementation of the ACA are cited among the reasons that have combined to make nursing the top occupation for job growth through 2022 (BLS, 2013). The following figures illuminate the specific need for additional nurses and nursing faculty in Maryland.

1. RN employment is projected to grow 22.3% in Maryland between 2008 and 2018 (DLLR, 2010). An estimated 19,450 RN job openings are expected in Maryland between 2012-2022 (DLLR, 2014)
2. In *Health Care 2020*, the Governor’s Workforce Investment Board (GWIB) called for an increase of up to 25% in the State’s health care workforce before 2020 to accommodate expanded access to coverage for an estimated 290,000 Marylanders under the ACA (GWIB, 2011).

3. The Health Resources and Services Administration (HRSA) reported in April 2013 that one third of the current national nursing workforce is older than 50 and will reach retirement age over the next 10-15 years. Maryland ranks 25<sup>th</sup> among states in its per capita RN workforce with 975.7 RNs per 100,000 population (HRSA, 2013).
4. The Bureau of Labor Statistics Employment Projections 2012-2022 indicates the RN workforce will grow from 2.71 million in 2012 to 3.24 million in 2022, an increase of 526,800 or 19%. The job openings for nurses due to growth and replacements will require an additional 525,000 RNs to meet the need for 1.05 million RNs by 2022 (BLS, 2013).

### **STAFF RECOMMENDATIONS FOR THE NSP II GOING FORWARD**

The NSP II has been a successful strategy for increasing and sustaining the State's academic capacity to produce nursing graduates while simultaneously maintaining the quality of those graduates as indicated by NCLEX pass rates. These goals have been achieved by increasing nursing faculty ranks through a "grow your own" program, adding new graduate level nursing programs, creating an educator certificate to help practitioners become effective nursing teachers, and by providing the necessary academic support and financial aid to attract nurses to graduate level education. At the same time, undergraduate programs including ADN to BSN programs have been implemented to ensure a strong supply of entry level nurses into the workforce.

<b>Recommendation 1: Renew NSP II funding for five years, FY 2016 through FY 2020.</b>
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Even so, with today's dynamic health care landscape it is unclear that nursing workforce demands have been met. In fact, based on the considerations outlined in the evolving issues section above, data suggest that the need for more highly trained nurses will continue to escalate which, in turn, will challenge nurse preparation programs to update curriculum, offer innovative instructional delivery, and increase enrollments. According to a sample of 50% (n=13) of Maryland Nursing Programs' 2012 reports, 1,120 qualified nursing applicants are still turned away due to enrollment limits (Maryland Deans and Directors, 2014). The NSP I, which was recently renewed, supports ongoing education for staff nurses with the goal of increasing nursing

quality placing further pressure on nursing programs. Therefore, MHEC and HSCRC jointly propose the following recommendations.

**Recommendation 2: Establish a work group to develop specific goals for a competitive institutional grant program and statewide initiatives based on the Institute of Medicine (IOM) recommendations.**

Assuming a renewal for NSP II, the program content of a new NSP II Phase 2 should be changed to address the evolving needs of hospitals and healthcare providers in Maryland. In developing revised and possibly new NSP II programs, it is imperative to take the changes in healthcare into account. The ACA, in particular, will have significant impact on the role of nurses in hospitals (and other settings), as hospitals move toward care coordination and improving health management models. Furthermore, selected recommendations from the IOM can serve as guidelines to enhance the quality of care. The key messages in the IOM report suggest that states should strive to 1) Improve education systems so that they promote seamless academic progression across broadly independent community college systems and university systems for nurses to achieve higher levels of education and training; and 2) Engage in effective workforce planning and policy making that requires better data collection and an improved information infrastructure. We recommend that although the program should still contain competitive institutional grants and statewide initiatives, the goals and initiatives should be updated to address these issues. These new goals should be set through a collaborative workgroup established by the HSCRC and MHEC.

**Recommendation 3: Adopt goals and metrics that address the following IOM recommendations: #4, #5, #6, & #7**

The following IOM Recommendations should serve as drivers for a new NSP II Phase 2.

**IOM Recommendation #4: Increase the proportion of nurses with a baccalaureate degree to 80 % of all RNs in the workforce.** As reported above, Maryland nursing programs are expanding enrollments and graduates, but the number of seats available in RN-BSN programs is unclear. A concerted effort in the Competitive Institutional Grants needs to be

directed through a specific initiative to address the 58% of Maryland's new nurse graduates with Associate Degrees. Meeting the goal of having 80% of all RNs becoming BSNs by 2020 will take seamless academic progression. NSP II has funded several models for dual enrollment to assist students in connecting with a university BSN program while enrolled in the community college. Metrics need to be developed to track the number of RN-BSN completions and the number of RN-BSN openings across Maryland. At present, graduations are not always identified as either new undergraduate BSN or RN to BSN completions. Efforts to increase BSN prepared nurses should take into consideration strategies to increase the diversity of the nursing workforce in race/ethnicity, gender and geographic distribution. The NSP II statute clearly supports increasing underrepresented groups in nursing to more closely mirror the population for whom they provide health services.

**IOM Recommendation #5: Double the number of nurses with a doctorate by 2020.**

Adding to the cadre of nurse faculty, nurse researchers, and advanced practice nurses is important to the future of the nursing workforce. Ensuring at least 10% of all BSN graduates matriculate into a master's or doctoral level program within five years of graduation is a goal worth pursuing. Continued funding for scholarships for tuition and all fees, faculty fellowships and grants for educational loan repayments, and completion of doctoral dissertations are key to maintaining the growth in graduate programs reflected in this report. Identifying promising undergraduates at earlier career points and guiding them into faculty roles is a specific goal for faculty as they mentor the younger generation of nurses.

**IOM Recommendation #6: Ensure that nurses engage in lifelong learning.**

Academic administration should provide support for all faculty to participate in continuing professional development. Demonstrations of educational excellence include obtaining and maintaining credentials and evidence of competence in practice, teaching and research. Foster a culture of lifelong learning and provide resources for inter-professional education.

**IOM Recommendation #7: Prepare and enable nurses to lead change to advance health.** Nursing education programs and nursing associations should prepare the nursing workforce to assume leadership roles across all levels. Health care decision makers should make room for nurses on boards and commissions to help make health decisions.

**Recommendation 4: Purchase software to manage and report on outcomes data.**

There are several administrative and operational issues to be considered as part of the administration of a new NSP II Phase 2. These recommendations stem from “lessons learned” in the administration of both the NSP I and NSP II, as well as emerging needs for evidence based practice in nursing education and workforce outcomes. One way to address some of these issues may be through a small competitive research grant program. Outcomes measures and data management are critical to making informed policy and programmatic decisions. In addition, software tools are needed to manage and analyze a high volume of outcomes data from the NSP II (and NSP I) projects. An investment in such software could also improve staff productivity by increasing ease of analysis and reporting.

Effort must be made for identifying metrics that link the “Triple Aim” with nurse sensitive measures and nursing workforce programs to demonstrate the connection of nursing professionals with population health delivery. Over the last 3 years, several multi-hospital studies added substantial support for a hospital-level association of nurse educational levels with patient outcomes. It was found that hospitals with a 10% higher BSN proportion had a 4%–7% lower 30-day mortality, reduced complication rates, and better outcomes on length-of-stay (LOS), measures of failure to rescue, congestive heart failure mortality, pressure ulcers, postoperative deep vein thrombosis or pulmonary embolism (Yakusheva, et al., 2014). MHEC and the HSCRC should investigate and possibly acquire *the Efforts to Outcomes* software or some similar software for the evaluation of NSP II over the next five year period.

**Recommendation 5: Review current NSP II statute, particularly the term “bedside nurses” to ensure that it meets the move toward a coordinated care model.**

Determine whether amended statutory language needs to be submitted to the Governor and legislature particularly the definition of “bedside nurses,” given the shift towards coordinated care approaches. The relevant statute is found at General Assembly Education Article, Section §11-405.

## CONCLUSION

The NSPII program has been successful in improving the pipeline for nurses and reducing the need for hospitals to depend on expensive nurse staff agencies. However, as a result of a combination of the recovery in the economy, the implementation of the Affordable Care Act, and the recent approval of the new All-payer model in Maryland, nursing functions and demands are changing. The NSP II program can be one tool to help Maryland enhance its nurse workforce to meet these new demands. During the course of this evaluation, it became evident that there is a continued need for coordinated nursing related data.

Recommendations in two key reports in 2011, *Health Care 2020* and the *Sunset Review: Evaluation of the State Board of Nursing*, focused on improved nursing data infrastructure in Maryland. The current Maryland Longitudinal Data System for education may serve as a model for this type of coordinated data collection. Although there was much discussion on IOM Recommendation 8 (build an infrastructure for the collection and analysis of inter-professional health care workforce data), this is not an issue that the NSP II can tackle alone. While outside the scope of the NSP II, but nonetheless related to its work, the State should charge agencies within the state such as DHMH, MBON, MHEC, Department of Labor, Licensing and Regulation, and GWIB to determine the best method of addressing data infrastructure. It represents a larger need within health workforce management and should be reviewed by a task force composed of representatives from multiple agencies and organizations.

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11400 Robinwood Drive • Hagerstown, Maryland 21742-6590 • 240-500-2000 • [www.hagerstowncc.edu](http://www.hagerstowncc.edu)

December 1, 2014

Mr. John Colmers  
Health Services Cost Review Commission  
4160 Patterson Avenue  
Baltimore, Maryland 21215,

Dear Mr. Colmers:

It is my pleasure to write a letter in support of the Nurse Support Grants (NSP). Hagerstown Community College has been very fortunate to have been awarded a number of these grants in the last several years. These grants have been very beneficial in helping our nursing program grow. Through the NSP II grant, we were able to almost triple the size of our nursing program.

In addition, we have been able to develop a remediation program whereby we have been successful in keeping many students from failing, thus increasing our retention rates. The grant also enabled us to purchase Assessment Technologies Institute (ATI) for each of our students. ATI not only helps students with remediation but has also helped to increase our NCLEX scores which remain some of the highest in the state.

Also, through the NSP 4 Simulation grant, we were able to establish a Simulation network throughout the state through which we helped the other community colleges in Maryland increase simulation in their nursing programs. Through this same grant, we were able to purchase simulators and other simulation equipment which helped to enhance our own simulation program at HCC.

In conclusion, I fully support your efforts to obtain additional money for grants to help our nursing programs.

Sincerely,

A handwritten signature in cursive script that reads "Karen Hammond RN, MSN".

Karen Hammond  
Director of Nursing  
Hagerstown Community College



Harford Community College  
401 Thomas Run Road • Bel Air, Maryland 21015  
410-836-4000 • 410-879-8920 • www.harford.edu

December 1, 2014

Mr. John Colmers  
Chairman  
Health Services Cost Review Commission  
4160 Patterson Avenue  
Baltimore, Maryland 21215

Dear Mr. Colmers:

On behalf of Harford Community College, please accept my highest recommendation for the continuation of the Nurse Support Program II (NSP II).

NSP II grant funding has played an integral role in the continued expansion and success of nursing offerings at Harford Community College. The following is only a brief list of the positive outcomes made possible by our NSP II grant award:

- The number of nursing graduates increased by more than 50 percent.
- An accelerated program that better utilizes resources during the summer semester was instituted.
- A weekend/evening program to take advantage of weekend clinical space availability was established.
- A Retention and Remediation Specialist was hired to assist our efforts of increasing student retention and completion.
- A Clinical Coordinator was hired to help with new clinical faculty orientation and ongoing training.

I firmly believe this program offers outstanding opportunities for increased capacity in nursing education and improved job readiness results. As such, I strongly endorse the NSP II program and its continuation.

Sincerely,

Laura Cianelli Preston, MS, RN  
Dean, Nursing and Allied Health Professions



Mr. John Comers  
Chairman  
Health Services Cost Review Commission  
4160 Patterson Avenue  
Baltimore, Maryland 21215

Regarding: Support for NSPII

Dear Mr. Comers:

I am writing in support of continuation for the Nurse Support Program. NSPII has been vital for the nursing program at Montgomery College. Montgomery College is a public, open admissions community college in Montgomery County, Maryland with campuses in Germantown, Rockville, and Takoma Park/Silver Spring. The college serves nearly 60,000 diverse students a year through credit and noncredit programs in more than 100 areas of study. The nursing program is located on the Takoma Park/Silver Spring campus. More than 170 countries are represented on campus. The number of foreign-born residents accounts for a remarkable 51% of the county's population. Many of the county's neediest residents live along the corridors adjacent to Washington, DC, where the Takoma Park/Silver Spring campus is located.

Montgomery College is committed to increasing the availability of competent, culturally diverse nursing graduates. Montgomery College has been expanding its Nursing Program over the past decade, so that the nursing program is now positioned to continue to increase enrollment. The target is to admit a maximum of 128 students per semester.

The Nursing Program at Montgomery College has received multiple NSPII grants.

- Staffing grant created a new clinical instructor role, which has had significant positive outcomes:
  - The clinical instructors have improved consistency of clinical instruction for the students where previously the program had some part-time instructors that were new each semester.
  - The clinical instructors have become a pool for future faculty. All of the clinical instructors have completed or are currently enrolled in master's degree programs. Three of the clinical instructors have become full-time faculty and one is the simulation coordinator.
  - I have shared the job description for the clinical instructor position with the other Maryland nursing programs.
- Nursing Enrichment Program
  - Created a position – Pre-Nursing Retention Coordinator. The role of this person is to provide support for pre-nursing students so that the students are able to meet the benchmarks for the nursing admission exam. Because of the high percentage of minority students at the college, additional resources and support are essential to maintaining the diversity of the nursing program.

- Established a retention plan within the nursing program. The retention plan is integrated throughout the nursing program, which has improved the program graduation rate to the current 76%-80%. This is an amazing success, particularly considering the diversity of the student population.
- Success Through Simulation
  - Through coordination with *Who Will Care*, the nursing program was able to develop a seven room simulation suite.
  - The NSPII grant created two new positions, a simulation technician and a simulation coordinator. Both of these positions are essential in supporting the complex technology in the simulation suite and providing support to the faculty in developing and running simulations.
  - Simulations are now integrated throughout the nursing program and used for both theory and clinical instruction.
  - An open-access online website has been created with simulation scripts and videos posted for use by any nursing program. This has been an amazingly successful site with site visits in the thousands.
- Model for Dual Enrollment
  - Although this was a planning grant with the University of Maryland School of Nursing (UMSON), the project has advanced to implementation with the memorandum of agreement (MOU) being signed between the UMSON and Montgomery College planned for this month.
  - The Dual Enrollment will allow MC nursing students to take courses concurrently if desired and seamlessly progress for completion of a bachelor's degree in nursing.
  - The MOU will be a model that the UMSON can use with other community colleges throughout the state.
- Military to ADN project
  - Because Montgomery College is located in an area with multiple military hospitals and bases, the nursing program has the ability to reach military medics and corpsmen who are interested in obtaining an associate degree in nursing.
  - A full-time faculty member who is a military veteran is coordinating the military project and has been able to develop progression plans for the military medics and corpsmen.

As a result of the utilization of these multiple diverse grants, MC's nursing program has been able to expand enrollment, as well as improving the access and quality of the program. The Montgomery County government and Montgomery College have made a commitment to the nursing program by funding the eight full-time positions that were established through the NSPII grants. This funding ensures that all the projects initiated through the grants will continue.

Additionally, a total of 29 faculty and full-time clinical instructors have received NSPII grant funds through the new faculty fellowships and doctoral support program. Because of this support, the number of doctoral prepared faculty has increased from one in 2006 to seven in 2014. Additionally, there are another seven currently enrolled in PhD and DNP programs. The

most successful part of this effort has been the increase in the number of diverse doctoral prepared faculty. A total of 69% of the awards were to diverse clinical staff and faculty.

As I have highlighted, the NSPII program has enabled MC's nursing program to grow and to improve. Without this ongoing support, I am concerned that continued innovation and improvement will be extremely difficult.

Thank you for your support for the NSPII program.

Sincerely,

A handwritten signature in cursive script that reads "Barbara Nubile".

Barbara Nubile, MSN, RN  
Associate Dean/Director of Nursing  
Montgomery College  
7600 Takoma Avenue  
Takoma Park, MD 20912-4197  
Phone: 240-567-5529 or 240-567-5530  
Fax: 240-567-5527  
Email: [Barbara.Nubile@montgomerycollege.edu](mailto:Barbara.Nubile@montgomerycollege.edu)



November 26, 2014

Mr. John Colmers, Chairman  
Health Services Cost Review Commission  
4160 Patterson Avenue  
Baltimore, Maryland 21215

Dear Mr. Colmers,

I am writing on behalf of the Department of Nursing at Salisbury University in support of the continuation of the NSP-II programs. The NSP-II programs have been instrumental in recruitment and retention of new nurse faculty to support expanded enrollments in our accelerated 2<sup>nd</sup> BS degree program and the development and launch of our DNP program, the only one located on the Eastern Shore of Maryland and the first post-BS to DNP entry option in the State of Maryland. Eight new nursing faculty have been supported by the New Nurse Faculty Fellowship (38% of our faculty), and three have received Nurse Educator Doctoral Grants expediting completion of their doctoral education.

The NSP-II program has also funded several institutional grants including a collaborative with two area hospitals (Peninsula Regional Medical Center and Atlantic General Hospital) to create shared hospital clinical faculty positions moving clinical experts into positions as educators with responsibilities for teaching students and staff. We were also the recipients of a second institutional grant collaborative with Chesapeake and Sojourner-Douglass Colleges to develop the Eastern Shore Faculty Academy and Mentoring Initiative. This project trains expert bachelor's prepared registered nurses to become part-time clinical faculty using online instruction, simulations and mentoring activities. To date, thirty nine new part-time clinical faculty have graduated from the Academy and are prepared for teaching assignments with one of the partner schools. Finally, we received a generous NSP-II grant to expand the availability of doctoral education in nursing to those on the Eastern Shore and throughout Maryland. As a result of this grant, we were able to launch our post-MS to DNP in Fall 2012 and our post-BS to DNP in Fall 2014, all in a distance accessible format with very limited trips to campus. We will graduate nine new DNPs in May 2015, two of whom are also completing requirements for certification as family nurse practitioners.

All of these initiatives have been aimed at addressing the nursing shortage in Maryland, through creating new roles in education, increasing the supply of part-time clinical faculty, and increasing availability and access to doctoral education. Each of these projects has connected directly to increased student enrollments and graduations, at both the undergraduate and graduate levels. None of the projects would have been

possible without the NSP-II program. It is a forward-thinking program that has benefitted the citizens of the State immeasurably. As you know, the “gray tsunami” has not yet arrived so our needs for highly qualified registered nurses in Maryland will only continue to grow. I heartily endorse continuation of the NSP-II program and hope you will too-it is vital to our ability to respond to the workforce needs of the State.

Sincerely,

A handwritten signature in red ink that reads "Lisa A. Seldomridge".

Lisa A. Seldomridge, PhD, RN  
Chair and Professor of Nursing  
Salisbury University  
Salisbury, Maryland  
laseldomridge@salisbury.edu

CC: [Oscar.Ibarra@maryland.gov](mailto:Oscar.Ibarra@maryland.gov).

November 14, 2014

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

Dear Chairman Colmers,

As Dean of the University of Maryland School of Nursing (UMSON), I would like to take this opportunity to thank the Health Services Cost Review Commission and the Maryland Higher Education for the funding support provided to our faculty and students through the Nurse Support Program II (NSPII). To date, our School of Nursing has been awarded over \$10.6 million in funding to support new educational programming, clinical site expansion, and faculty development initiatives. We are especially proud of the impact that the current funding has had on nursing education at our School and our ability to increase the pipeline of nurses who hold a baccalaureate degree or higher. But more remains to be done.

The Affordable Care Act, described as the biggest overhaul of the U.S. health care system since the passage of Medicare and Medicaid in 1965, is aimed at increasing health care coverage to all Americans while also cutting costs and improving efficiency of the country's health care system.

Its success may well depend on nurses. We need to know how we can be part of the solution to achieve better patient outcomes at a more reasonable cost. We need to do more to prevent disease; provide chronic care management to an aging, sicker, and more diverse population; and offer end-of-life care that emphasizes comfort and compassion. Across all settings, we must do more to prepare ourselves for the future.

Nursing has a central role to play in realizing the promise of health reform—a transformed health system that provides wide access to essential health services while improving quality and controlling costs. Simply put, these national goals cannot be achieved without maximizing the contributions of nurses.

There are ongoing and future needs for a well-educated nursing workforce, including faculty. We need to continue to emphasize the need for doctorally-prepared nursing faculty. The evolving nursing shortage, the greying of the nursing faculty, and a large “brain drain” of experienced faculty expected in the next 5-10 years as retirements dramatically increase (those who stayed during the recent economic downturn are now seriously ready to retire!) are all reasons we need to have well-educated nursing faculty to prepare the next generation of nurses who will care for populations, communities, individuals and families within the new models of care delivery. This education should span initial academic preparation for teaching as well as ongoing professional development of current faculty to assure currency with contemporary educational practices and to optimize maximizing of technologic resources to support learning.

It appears that although the NSP II grants were originally conceptualizing bedside nursing to hospital based nursing, there is now an opportunity to potentially broaden future funding to go across the care continuum, from population/community to ambulatory to hospital to nursing homes and beyond.



As you evaluate the current NSPII Program, I would like to respectfully offer some suggestions for future areas of focus for NSPII funding:

- Advancing nurse led care coordination across the continuum. Care coordination is central to training BS, CNL and advanced practice students.
- Support for education at the DNP advanced practice level with a focus on primary care (including mental health). For example, 1) funds to secure optimal primary care clinical rotations which are critical to capacity building in the FNP, PNP and AGPCNP programs and 2) funds to recruit and retain faculty in those programs.
- Support for academic/clinical practice partnerships (in particular practice focused faculty positions at the RN and NP level) to increase clinical learning sites.
- Support to start a nurse managed health center for the purposes of clinical education at all levels (focusing on issues needed to support the Maryland Medicare Waiver... transitions, chronic disease, care management, population health).
- Development of an educational focus on care management and care coordination either within the CPH curriculum or the HSLM curriculum; as a certificate program; or as a focus area in the post-master's DNP program.
- Focusing part of the NSP call on clinical simulation as an avenue to increase capacity. The recent outcomes from the National Council of State Boards of Nursing's longitudinal multi-site study on the efficacy of simulation as a replacement for traditional clinical hours.
- Promoting care collaboratives between academic and clinical partnerships to focus on improving nurse sensitive outcomes, transitions of care and nursing processes.
- Initiatives that include preparation for teaching as part of doctoral programs in nursing.
- Health promotion and disease prevention by (a) supporting doctoral level nursing education for population health care (community and public health) and primary care for underserved, and (b) supporting systems which hire doctorally-prepared community/public health and primary care nurses through faculty practice arrangements in which faculty will precept doctoral students in these roles.
- Opportunities for interprofessional learning and practice.

Thank you for this opportunity to comment.

Sincerely,



Jane Kirschling, PhD, RN, FAAN  
Dean and Professor, School of Nursing  
University Director Interprofessional Education  
University of Maryland, Baltimore

November 14, 2014

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

Dear Chairman Colmers:

On behalf of the University of Maryland, Baltimore (UMB), I am writing to express our gratitude for the Nurse Support II (NSPII) Program administered by the Maryland Higher Education Commission (MHEC). As the Health Services Cost Review Commission (HSCRC) meets to evaluate the program, I would like to share with you the enormous impact this statewide initiative has had on our University, our faculty and students, and the health care community throughout the state of Maryland and beyond.

Since the launch of the NSPII Program in 2006, the University of Maryland School of Nursing has been awarded more than \$10.6 million in funding. This included \$9.5 million for educational programming and \$1.1 million to aid our nursing faculty with continuing education and professional development. Maryland is the only state in the nation to provide this level of financial support for nursing education, and HSCRC's generosity has been vital to maintaining our role as a national leader in health sciences research, public service, and patient care. Given UMB's budgetary constraints during the recent economic downturn, this funding proved to be crucial in allowing us to continue our stated mission of improving the health and well-being of the residents of our state and better serve the region by producing the next generation of nurses for the Maryland workforce.

As the largest nursing school in the state and one of the largest in the nation, the NSPII funding allowed us to leverage our strengths by recruiting and retaining new faculty members, advancing the education and training of our current faculty, and creating innovative educational programs that were responsive to the needs of health care employers. This includes developing the region's first Doctor of Nursing Practice (DNP) Program, from which we have produced 99 graduates. This program proved to be such a success that four other institutions in the state have since added this degree offering. Another NSPII initiative from the University of Maryland was a partnership between our School of Nursing, the University of Maryland Medical

Center, and Franklin Square Hospital Center to develop an online master's program that would encourage staff nurses to serve as clinically based nurse educators. We were able to prepare 100 hospital-based nursing faculty, which expanded the number of clinical instructors and increased clinical access and enrollments for nursing students in Maryland. This is just a small sample of our outcomes, but it demonstrates the broad reach of the NSPII funding.

We are committed to continuing this important work and look forward to our sustained partnership with MHEC. We appreciate the opportunity to share our support for this vital statewide initiative.

Sincerely,

A handwritten signature in blue ink, appearing to read "Jay Perman". The signature is fluid and cursive, with a large loop at the end.

Jay A. Perman, MD

# Medicaid Savings

December 10, 2014

# Legislative Charge

- HSCRC and DHMH in consultation with Maryland Hospital Association (MHA) are required to develop a methodology for calculating the general fund Medicaid savings if any generated by the Maryland All-Payer Model Contract.
  - “... model the methodology for calculating general fund savings in the Medicaid Program by comparing an average baseline of Maryland Medicaid total risk-adjusted hospital expenditures per beneficiary over a reasonable period of time before the implementation of the Maryland All-Payer Model Contract to the actual Maryland Medicaid total risk-adjusted hospital expenditures per beneficiary during the period under Maryland’s All-Payer Model Contract.”
  - Governor directed to incorporate into the State budget a reduction to the Medicaid deficit assessment equivalent to any general fund savings identified.

# Analytic Approach

- CY 2013 to serve as base period (pre-Model Contract implementation)
  - CRISP matched Medicaid eligibility files for CY 2013 with claims Abstract data collected by HSCRC to identify hospital charges for Medicaid enrollees.
  - Per Member Per Month (PMPM) Charges calculated for each Medicaid eligibility category.
- CY 2014 Expected Charges Calculated
  - CY 2013 PMPM charges for each eligibility category inflated by trend factor (developed based on recent experience and discussed further on next slides) to estimate CY 2014 expected PMPM charges.
  - Expected CY 2014 charges = Expected CY 2014 PMPM for each eligibility category X # of CY 2014 covered months by eligibility category
- Savings = Expected CY 2014 Charges Compared to Actual CY 2014 Charges
  - Actual CY 2014 charges identified by CRISP through matching of Medicaid eligibility files and HSCRC abstract data.
- Analysis compared first half of CY 2013 to first half of CY 2014 as only 6 months of nearly complete Medicaid eligibility files are available for CY 2014.
  - 4% completion factor applied.

# Expected Trend

- No single data set provided historic data by eligibility category.
  - Medicaid provided comprehensive Maryland hospital utilization data by eligibility category for 2009-2013 but could not provide associated charge/payment data.
  - HSCRC Abstract data captures only aggregate expected Medicaid charges.
  - Significant changes in Medicaid enrollment mix resulting from 2008 expansion and recession necessitate analysis of trends at the eligibility category level rather than the aggregate level.
- Alternate approach isolated trends in price, utilization, and intensity
  - Case mix intensity trend calculated by HSCRC using changes in case mix index.
  - HSCRC's annual update factors capture trends in price.
  - Medicaid MCO utilization data by eligibility category.

# Expected Trend (cont.)

- Trend developed based on review of experience from 2009 to 2013.
- Discarded outliers
  - Update factor for 2013 discarded due to extraordinary actions to maintain prior waiver.
  - Utilization analysis excluded eligibility categories experiencing substantial growth (as newer enrollees utilized less care than existing population).
  - ACA expansion population excluded as federal government pays 100% of claims.



# Final Trend Factor

- Final Trend Factor for CY 14 (first six months) of 1.88%
  - Price: +2.34%
  - Utilization/Case Mix: -0.46%
- Selection of trend for future periods will be developed during preparation of next year's savings calculation. Further analysis required due to:
  - FY 2015 policy changes which will influence magnitude and direction of expected trend.
    - Medicaid presumptive eligibility
    - MHIP and Uncompensated care reductions
  - Medicaid enrollment instability (growth) depressing short-term trend.
    - ACA expansion is generating significant CY 2014 growth in enrollment by less poor parents and children in non-expansion eligibility categories.
    - Based on prior experience, these new parents/children are expected to utilize less care than the typical/parent child in same eligibility group.

# Results & Next Steps

- \$14.5 million of State savings in first six months of CY 2014.
  - Department of Budget and Management notified of results.
  - Formal transmission of results to occur this week.
- CRISP working with Medicaid/HSCRC staff to refine and improve process for linking Medicaid eligibility files with HSCRC hospital charge data.
- DHMH, HSCRC, and MHA staff to monitor results quarterly and review methodological issues (e.g. completion factor, changes to assessments, presumptive eligibility) in preparation for 2015 savings calculation.

Medicaid Savings Calculation  
CY 2014

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

December 2014

## Background

The Budget Reconciliation and Financing Act of 2014 (Chapter 464 Acts of 2014) requires that the Health Services Cost Review Commission (HSCRC) and the Department of Health and Mental Hygiene (DHMH) in consultation with the Maryland Hospital Association (MHA) develop a methodology for calculating the general fund Medicaid savings, if any, generated by the new Maryland All-Payer Model Contract.

The law specifies that:

“The Commission and the Department of Health and Mental Hygiene shall model the methodology for calculating general fund savings in the Medicaid Program by comparing an average baseline of Maryland Medicaid total risk-adjusted hospital expenditures per beneficiary over a reasonable period of time before the implementation of the Maryland All-Payer Model Contract to the actual Maryland Medicaid total risk-adjusted hospital expenditures per beneficiary during the period under Maryland’s All-Payer Model Contract.”

DHMH, HSCRC, and Maryland Hospital Association staff met three times during the Fall to determine the appropriate approach to calculating savings. The group reviewed recent trends in HSCRC rate updates, Medicaid hospital spending at Maryland hospitals, Medicaid utilization of Maryland hospitals by eligibility category, and changes in the intensity of services provided to Medicaid patients served at Maryland hospitals.

## Analysis

After extensive review of the data, different underlying growth rates may be appropriate for developing the expected trend for the current period (the analysis of savings for the period January to June 2014) and future periods. A modest growth rate of 1.88% was selected for the current period as Affordable Care Act implementation is generating significant enrollment growth by parents and children in non-expansion eligibility categories. Based on the experience from 2009 to 2013 when the number of less poor parent/child enrollees surged due to a State Medicaid expansion and the recession, the new non-expansion parents and children are expected to utilize fewer services than the typical parent/child enrollee. More robust expenditure growth appears likely in future periods as Medicaid enrollment stabilizes. However, other factors including implementation of new Medicaid presumptive eligibility policies, changes in State policy concerning various assessments, and declines in uncompensated care will also influence the magnitude and direction of the expected trend and require further analysis before an appropriate trend can be established. Selection of a specific trend for future periods will be developed during preparation of next year’s Medicaid savings analysis.

The underlying growth rate for the current period captures volume, and case mix trends from the period FY 2010 to FY 2013 and price trends from the period FY 2009 to FY 2012 (FY 2013 was discarded as an outlier). A fuller discussion of the components of the growth rate are provided later in this document.

The calculation of Medicaid savings since the implementation of the new Model Contract was developed by determining expected spending for the first six months of CY 2014 and comparing this spending level to actual spending for the first six months of the year. Expected spending was calculated by inflating actual CY 2013 per member per month charges for the period January to June 2013 for each Medicaid eligibility category by the underlying growth rate and then multiplying this number by the actual CY 2014 enrollees in each eligibility category. The resulting total was then compared to the actual spending for this period (enrollees qualifying for Medicaid through the Affordable Care Act expansion in 2014 were excluded from the analysis as 100% of their costs are paid with federal funds). General fund savings were assumed to represent 50% of the total savings since the State pays roughly 50% of Medicaid costs. A step by step explanation of the calculation is provided in Appendix 1.

**As shown in the table below, the methodology produces a Medicaid savings figure of \$29 million for the first half of the calendar year. The general fund share of this savings is \$14.5 million.**

Since CY 2014 expenditure data for the period beyond June 2014 is incomplete (as some Medicaid patients qualify for retroactive eligibility) and the law specifies the use of actual expenditures in the analysis, the savings calculation is limited to the six month period for which nearly complete data is available. There are a number of factors that could result in a different trend for the remainder of the calendar year including the hospital rate update in July 2014, a reduction to the uncompensated care built into hospital rates, retroactive eligibility determinations increasing the actual Medicaid spending in the January to June 2014 period by more than assumed in the analysis, the introduction of new Medicaid presumptive eligibility policies, and the impact on utilization of the ongoing implementation of the waiver.

### **Data Limitations Drive Approach to Trend Development**

The approach to analyzing the historic growth in Medicaid charges on a risk-adjusted basis was driven in large part by data limitations. HSCRC claims Abstract data capture annual hospital spending on patients whose expected payer is Medicaid. However, for periods prior to CY 2012, these data cannot be disaggregated by eligibility category, and the expected payer designation is often incorrect. Data collected by Medicaid from MCOs capture utilization of Maryland hospitals by broad eligibility categories, but payment data linked to each visit/admission to a Maryland hospital are not available.

Given these limitations, analysis of the baseline trend used a variety of data sources but ultimately relied on three components:

- Medicaid provided utilization data by eligibility category;
- HSCRC rate update factors for inpatient and outpatient hospital charges; and

- HSCRC data on changes in the intensity of Medicaid hospital visits over time.

Detail on the analysis of the three components is provided below.

### Price

The HSCRC's annual inpatient and outpatient rate update factors for the period FY 2006 – FY 2013 are presented in the chart below. The relatively low rates of growth for the period FY 2010 to FY 2013 reflect downward pressure to maintain compliance with the old waiver, generally low national inflation rates, and modest rates of growth in national Medicare hospital rates over the same period. Growth rates in prior years reflect both a period of more robust Medicare rate increases and the large cushion Maryland had under its Medicare test.

The fiscal 2013 update was discarded as an outlier since the negative trend reflected extraordinary actions taken by the HSCRC to ensure that Maryland remained in compliance with the previous All-Payer waiver, while development of the new waiver proceeded. The discussion then focused on the appropriate balance between the modest growth rates in the current period and the more robust growth in the earlier period. Greater weight was given to the period of low growth for development of the trend factor, since modest growth in national Medicare hospital rates is expected to continue over the next few years.

Two alternative approaches were considered:

- (1) The average trend for FY 2010 to FY 2012 of 1.68% (for both inpatient & outpatient).
- (2) The average trend for FY 2009 to FY 2012 of 2.31% (inpatient) and 2.38% (outpatient).

The first option was deemed to weight a historically low period of hospital inflation too heavily. National estimates of per capita hospital expenditures produced by CMS's Office of the Actuary anticipate an uptick in growth in the coming years. Similarly CMS estimates of the Medicaid inpatient hospital market basket for 2015, 2016, and 2017 anticipate growth of 2.9% to 3% compared to the market basket factors of at or below 2.6% in the period 2010 to 2012.

#### Annual HSCRC Rate Updates

Fiscal Years 2006 -2013

	2006	2007	2008	2009	2010	2011	2012	2013
Inpatient	4.64%	3.56%	3.81%	4.20%	1.49%	2.00%	1.56%	-5.81%
Outpatient	3.98%	3.56%	4.00%	4.50%	1.49%	2.00%	1.56%	2.59%

## Utilization

Medicaid provided utilization data for each category of eligibility for the period FY 2009 to FY 2013. During this period, Medicaid enrollment rose by more than 300,000 or 32% due to the State's 2008 Medicaid expansion and the effects of the economic downturn. While Medicaid covers a range of populations including poor elderly, the disabled, and low income children and parents, almost all of the enrollment growth was among children and parents. The disproportionate growth in children and parents impacts the overall utilization trend as these groups are lower utilizers of care than the disabled and elderly. To avoid the enrollment shifts from distorting the underlying growth rate, trends for the disabled and children and families were analyzed independently.

Further disaggregation was required as substantial shifts in utilization were observed within specific eligibility categories that experienced dramatic enrollment growth. For example, the largest Medicaid eligibility category for children and families (capturing less poor children and parents) experienced more than 100% enrollment growth from 2009 to 2013. The new enrollees produced a very different utilization pattern for the eligibility category - inpatient admissions per 1,000 enrollees declined at an average annual rate of 6.4% while outpatient visits declined at an average annual rate of 1.6%. Utilization by children and parents qualifying through other more stable enrollment categories was quite different with inpatient admissions per 1,000 declining at an average annual rate of 0.9% and outpatient visits rising by an annual rate of 1.6%.

To avoid the myriad of distortions produced by the enrollment instability, the utilization rates utilized for the underlying trend reflect the experience in the more stable enrollment categories including disabled individuals receiving SSI benefits and the eligibility categories capturing the poorest children and parents.

Annual growth rates for the period 2009 to 2013 were reviewed. The choice of years has a substantial impact on the results as shown in the tables below. The 2009 to 2012 trend (-1% inpatient and +1.9% outpatient) was viewed as a reasonable predictor of future growth if Medicaid enrollment stabilizes. Non-ACA expansion enrollment, however, is not stable with less poor parent and child enrollments continuing to increase. Based on the 2009 to 2013 experience with utilization rates for the rapidly growing eligibility groups, this enrollment growth can be expected to push Medicaid utilization rates down. To better capture the impact of the ongoing change in enrollment mix, the utilization trend for the period 2010 to 2013 (-2.9% inpatient and +0.22% outpatient) was incorporated into the underlying trend analysis for the current period.

**Medicaid Utilization for Selected Eligibility Categories - Average Annual Growth 2009 - 2012**

	Inpatient Admissions	Outpatient Visits
Stable Categories of Children and Family Enrollees	-1.1%	1.8%
Disabled - SSI Only	-1.5%	2.1%
<b>Composite (weighted based on share of admissions/visits in 2013)</b>	<b>-1.3%</b>	<b>1.9%</b>

**Medicaid Utilization for Selected Eligibility Categories - Average Annual Growth 2010 - 2013**

	Inpatient Admissions	Outpatient Visits
Stable Categories of Children and Family Enrollees	-2.7%	2.1%
Disabled - SSI Only	-3.1%	-0.9%
<b>Composite (weighted based on share of admissions/visits in 2013)</b>	<b>-2.9%</b>	<b>0.2%</b>

**Case Mix**

Using the HSCRC equivalent case mix adjusted discharge methodology, an analysis of the intensity of inpatient Medicaid admissions and outpatient visits from FY 2010 thru FY 2013 was performed. Over this period, inpatient intensity (as measured by change in the case mix index) rose by 0.6% per year, while the intensity of outpatient visits increased 2.5%.

[Putting It All Together](#)

The overall trend was calculated as shown below. Separate inpatient and outpatient rates were calculated. The inpatient and outpatient rates were then weighted based on their relative share of total Medicaid hospital charges included in HSCRC abstract data for FY 2013.

Underlying Trend = (1+ price growth rate) \* (1+ utilization growth rate) \* (1+ case mix intensity growth rate)

The underlying trend was then applied to the actual hospital charges for the first half of calendar 2013 for each category of Medicaid to estimate the charges per member month in each enrollment category for 2014. The expected 2014 charges were then compared to actual 2014 charges. Identification of the actual calendar 2013 and 2014 charges by eligibility category was performed by CRISP using its unique patient identifier to match



individuals from the Medicaid enrollment file with charges captured in the HSCRC's medical abstract and billing data.

### Next Steps

Medicaid and HSCRC staff will work with CRISP to refine and improve the process for linking Medicaid eligibility files with hospital charge data collected by the HSCRC.

HSCRC, DHMH, and Maryland Hospital Association staff will meet quarterly to monitor trends in savings, evaluate whether the 4% completion factor is appropriate for future use, review the results of the enhancements to the CRISP process, and further refine the methodology. Selection of a trend factor for future periods will be made once the stability of Medicaid enrollment post-ACA implementation can be more fully assessed.

Appendix 1	
Steps	Calculation
Step 1 - Develop "Expected Trend"	Expected trend = Underlying growth rate agreed to by DHMH and HSCRC after review of price, utilization, and case mix data for period from FY 2009 to FY 2013.
Step 2 - Calculate Projected Medicaid Charges for first six months of 2014.	
a. Calculate actual per member month hospital charges for each Medicaid eligibility category for the first six months of CY 2013.	CY 2013 Per Member Per Month (PMPM) Charges = Actual 2013 Charges/Actual 2013 Member Months
b. Calculate expected CY 2014 per member month charges for each Medicaid eligibility category by applying "Projected Trend" to the Per Member Month Calculation for each eligibility category .	Expected CY 2014 PMPM Charge = CY 2013 PMPM Charges * (1+ Expected Trend)
c. Multiply expected per member month spending for each eligibility category in CY 2014 by the number of actual CY 2014 member months in that eligibility category.	Expected CY 2014 Charges for Eligibility Category = Expected CY 2014 PMPM Charge * Actual CY 2014 Member Months
d. Sum the projected spending for each eligibility category to arrive at expected spending level for first half of CY 2014.	Expected Medicaid Charges CY 2014 = Sum of Expected Charges for Each Eligibility Category
Step 3 - Increase spending for CY 14 by 4% to capture delays in claims runoff .	Expected Medicaid Charges for CY 2014 * 1.04
Step 4 - Calculate Total Medicaid Savings by Comparing Projected to Actual Charges and discounting charges by 6% as Medicaid pays only 94% of charges	Total Medicaid Savings = (Actual Medicaid Charges CY 2014*94%) - (Expected Medicaid Charges CY 2014 *94%)
Step 5 - General Fund Savings at 50% (rough share of Medicaid charges paid by State)	General Fund Savings = Total Medicaid Savings * 50%



Maryland  
Hospital Association

December 8, 2014

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

Dear Ms. Kinzer:

This letter is written in response to Director David Romans' draft report on the methodology used to calculate general fund Medicaid savings, if any, generated by Maryland's new All-Payer Model contract. On behalf of the Maryland Hospital Association's (MHA) 65 member hospitals and health systems, I want to offer my thanks to the commission and to the Department of Mental Health and Hygiene (DHMH) for working with us to develop this methodology in a timely fashion. MHA supports both the methodology and the initial general fund savings estimate of \$14.5 million for the first six months of calendar year 2014. We are committed to working with you and the commissioners to ensure that the state's Medicaid budget for fiscal year 2016 recognizes these savings, and results in an equivalent reduction in the Medicaid hospital deficit assessment for the next fiscal year. Doing so will contribute to providing Maryland's hospitals with the important flexibility they need to succeed under the new waiver.

I particularly would like to single out Director Romans for his diligent work to sort through the intricate details of the data needed to reach a reasonable estimate of the trend in expected Medicaid expenditures prior to implementation of the state's all-payer model last January, as required by the Budget Reconciliation and Financing Act of 2014. While the Act requires an annual assessment of these savings, MHA will also work with HSCRC and DHMH on a quarterly basis to continue reviewing the trends and assumptions used in this methodology, so that we can together further substantiate the annual general fund savings estimates.

Again, my thanks to both HSCRC and DHMH for allowing MHA to be part of this important methodology development and savings estimate. If you have any questions, please contact me.

Sincerely,

Michael B. Robbins  
Maryland Hospital Association  
Senior Vice President

Staff Recommendation

Request by the Medical Assistance Program to Modify the Calculation  
of Current Financing Deposits for CY 2015

December 10, 2014

This final recommendation was approved by the Commission at the December 10, 2014 meeting.

## Introduction

The Medical Assistance Program (MAP) has been providing working capital advance monies (current financing) to hospitals for many years. As a result, MAP receives the prompt pay discount as per COMAR 10.37.10.26(B). MAP is unique among third-party payers in that it is a governmentally funded program that covers qualified poor residents of Maryland. As such, it deals, to a large extent, with retroactive coverage. Recognizing the uniqueness of MAP, the Commission allowed MAP to negotiate a special formula with the hospital industry to calculate its fair share of current financing monies. The Commission approved this alternative method of calculating current financing at its February 1, 1995 public meeting. Currently MAP has approximately \$94 million in current financing on deposit with Maryland hospitals.

As a result of the state budget crisis, MAP requested, and the Commission approved, an exception to the requirement that the amount of current financing on deposit with hospitals be re-calculated annually based on the alternative methodology approved by the Commission for CYs 2009 through 2013. MAP also proposed that there be changes in its current financing formula when its new claims system, which is projected to achieve a dramatic reduction in hospital receivables, is implemented.

As a result of continuing budget shortfalls, on February 24, 2014, MAP requested an exception to the approved current financing calculation for FY 2014. MAP requested that it be permitted to increase the current financing amounts on deposit with each hospital by the HSCRC's update factor for FY 2014. MAP's request was granted by the Commission at its May 14, 2014 public meeting.

## MAP's Current Request

MAP requests that it be permitted to increase the current financing amounts on deposit with each hospital by the HSCRC's update factor for FY 2015 (2.41%). MAP also reported that it would report a revised implementation timeline for deploying its new claims system.

## Staff Recommendation

Based on the current condition of MAP's budget, staff recommends that the Commission approve MAP's request. Staff also recommends that the approval be subject to the requirement that MAP continue to report annually on the status of the implementation of its new claims system.



STATE OF MARYLAND  
**DHMH**

Maryland Department of Health and Mental Hygiene

201 W. Preston Street • Baltimore, Maryland 21201

Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – Joshua M. Sharfstein, M.D., Secretary

**MEMORANDUM**

To: Dennis Phelps, Associate Director, Audit and Compliance  
Health Services Cost Review Commission (HSCRC)

From: Charles Lehman, Acting Deputy Secretary  
Health Care Financing

Date: November 13, 2014

Subject: CY 2015 Current Financing Deposits

NOV 17 '14 AM 11:56

The Department of Health and Mental Hygiene (DHMH) is proposing the continuation of the modified current financing formula for the Calendar Year (CY) 2015 inpatient and outpatient financing deposits. The current modified financing formula allows the existing Medicaid financing amounts for each hospital to be increased by the final update factor, as calculated by the HSCRC for the current rate setting year. Consequently, the DHMH would like to request that our proposal to continue the current modified financing formula be submitted at the next Commission meeting for approval.

DHMH continues its work to replace the existing MMIS claims system. A revised implementation timeline will be provided when available. Additionally, a new federal requirement was implemented during October 2014 which requires state Medicaid programs to reimburse hospitals for services provided to individuals who qualify for Hospital Presumptive Eligibility (HPE). Hospitals may make temporary, on-site Medicaid eligibility determinations based on basic, self-attested income and demographic information. The Medicaid program will reimburse for covered services during HPE coverage even if the individual is ultimately determined ineligible for Medicaid. Thirty seven hospitals have enrolled in the program and its employees completed training and passed knowledge training.

Should you have questions or require additional information, please contact Ardena M. Walker at 410-767-5196 or via email at [ardenam.walker@maryland.gov](mailto:ardenam.walker@maryland.gov).

cc: Audrey Parham-Stewart  
Michael Robbins, MHA  
Ardena Walker  
Keith Sewell

Toll Free 1-877-4MD-DHMH • TTY for Disabled - Maryland Relay Service 1-800-735-2258

Web Site: [www.dhmm.state.md.us](http://www.dhmm.state.md.us)

State of Maryland  
Department of Health and Mental Hygiene



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**Health Services Cost Review Commission**

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Hospital Rate Setting

Sule Calikoglu, Ph.D.  
Deputy Director  
Research and Methodology

**TO: Commissioners**

**FROM: HSCRC Staff**

**DATE: December 10, 2014**

**RE: Hearing and Meeting Schedule**

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January 14, 2015	Time to be determined, 4160 Patterson Avenue HSCRC Conference m Room
February 11, 2015	Time to be determined, 4160 Patterson Avenue HSCRC Conference m Room

Please note that Commissioner's binders will be available in the Commission's office at 11:45 a.m.

The Agenda for the Executive and Public Sessions will be available for your review on the Thursday before the Commission meeting on the Commission's website at <http://www.hsrc.maryland.gov/commission-meetings-2014.cfm>

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