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



# 488th MEETING OF THE HEALTH SERVICES COST REVIEW COMMISSION
**May 2, 2012**

## EXECUTIVE SESSION
**12:30 p.m.**

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

## PUBLIC SESSION OF THE HEALTH SERVICES COST REVIEW COMMISSION
**1:00 p.m.**

1. **Review of the Executive Session and Public Meeting Minutes of the April 11, 2012 Meeting**

2. **Executive Director's Report**

3. **Docket Status – Cases Closed**

   2155A – University of Maryland Medical Center

4. **Docket Status – Cases Open**

   2157N – Levindale Hospital

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

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

7. **Draft Recommendation on Variables for Uncompensated Care Calculation**

8. **Hearing and Meeting Schedule**

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

AS OF APRIL 23, 2012

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

| Docket Number | Hospital Name | Date Docketed | Decision Required by: | Rate Order Must be Issued by: | Purpose | Analyst's Initials | File Status |
|---|---|---|---|---|---|---|---|
| 2157N | Levindale Hospital | 4/20/2012 | 5/21/2012 | 9/17/2012 | Rebundled Rates | CK | OPEN |

PROCEEDINGS REQUIRING COMMISSION ACTION - NOT ON OPEN DOCKET

# Update Factor Recommendation for FY2013

May 2, 2012

This recommendation is ready for Commission action.

## DISCUSSION

1. Introduction

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2. Status of the Waiver

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

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

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

The waiver letters typically lag current events by 15 to 18 months. *Monitoring Maryland Performance* for year ending February 2012 shows that the Charge per Case is growing by 8.69%, far above the 4.3% budgeted under last year's update factor discussions (update factor plus the Medicaid assessment plus seed funding for ARR). This high run rate is contributing to an erosion of the projected waiver cushion.

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

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

*Table 1: Factors Contributing to FY2012 Charge per Case Growth*

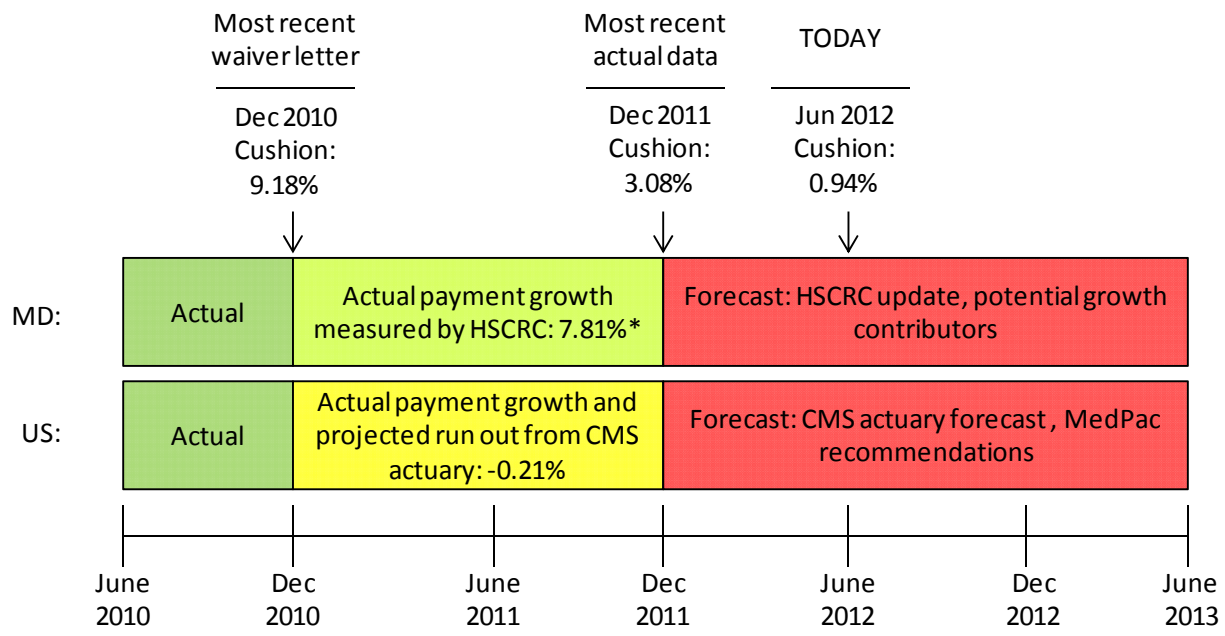
| Factor | Impact (percentage points) |
|---|---|
| Core Update Factor | 1.56 |
| Medicaid Assessment | 1.90 |
| Rate Realignment | 1.60 |
| Seed Funding (ARR, TPR) | 0.50 |
| Short Stay Cases | 3.00 |
| Other | 0.16 |
| **Total** | **8.69** |

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

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

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

*Figure 1: Updated Wavier Forecast*




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

3. Financial Condition of Hospitals

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

*Table 2: Profits and Losses – Disclosure Report*

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

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

Table 3 summarizes financial performance for the first seven months of FY2012 compared to similar reporting for the first seven months of FY2011. The average regulated net operating margin has declined to 4.39% from 4.95% in FY2011, and average total net operating margin declined to 2.09% from 2.89% the previous year. While the data are not as accurate as the audited annual data, they show a trend toward lower profitability from operations. While limited update factors in previous years contribute to this decline, our analysis suggests that growth in expenses has outstripped revenue by nearly a percentage point. (Data from February 2012 indicate that total operating margins increased to 2.59%, but these results appear to be driven by a single hospital and require further review.)

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

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

4. Short Stay Cases

The removal of short stay cases from the CPC methodology, while hospitals have increased utilization of observation services, has contributed to an increase in the average charge per case in Maryland, eroding our waiver status substantially. Under this policy, cases with 0 and 1 day length of stay were excluded from the CPC methodology. However, rate capacity for these cases remained in rates as the short stay cases were excluded from the CPC and valued at charges, raising the average CPC for the remaining cases included in the CPC for the remaining cases.

This process has been happening gradually throughout FY2011 and FY2012, and the data suggest that the process will continue in FY2013. For the first eight months of FY2012, the effect of the shifts to observation is contributing approximately 3 percentage points of the observed 8.69% growth for all payers in the first eight months of the fiscal year. If this effect continues, the update factor for FY2013 must offset that impact to maintain compliance with the State's waiver.

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

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

short stay cases. To avoid unintended consequences of this sort, reintegration of short stay cases into the target is not an appealing solution.

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

5. Admission Readmission Revenue (ARR) Policy

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

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

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

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

6. Total Patient Revenue (TPR)

FY2013 is the third and final year of the current Total Patient Revenue agreements. The phenomenon of moving low intensity cases from the hospital to more appropriate settings is similar to the phenomenon experienced with short stay cases and with reduced readmissions.

Because low acuity, low charge cases are likely to be moved to other settings, remaining cases are likely to be more expensive, increasing the charge per case and resulting in further waiver deterioration. We estimate the impact for FY2012 to be 0.22% for Medicare charge per case. Assuming this trend continues for another year, we would need to offset this rise in the update factor.

7. Medicaid Assessments

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

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

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

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

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

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

8. Waiver Modernization

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

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

9. Improved monitoring and control of the system

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

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

## RECOMMENDATIONS FOR FY2013 RATES

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

***Recommendation 1: Apply an update factor of -1% for hospital inpatient rates. The update would be applied as -1.25% on inpatient rates with an allowance from 0.25 percentage points of case mix growth for a net effect of -1% overall.***

The staff believes that an inpatient update of -1% is necessary to generate even a minimal waiver cushion. An adjustment of -1% will produce some waiver cushion and allow the system time to negotiate a modernized waiver under the CMMI States' Initiative.

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

The 3 percentage point growth associated with the short stay cases appears to be large given the movement witnessed to date. However, Maryland hospitals started at a rate of 22.5% readmissions and through the first half of this fiscal year were around 18.5%. The national average sits at about 14%. Given the distance we have to go and the fact that hospitals have moved differentially on this front, further erosion is likely to continue. This is consistent with the increase in the reported charge per case in *Monitoring Maryland Performance* for year-ending February 2012 of 8.69%.

Within the -1% update for inpatient services, we recommend it be applied as a -1.25% update with an allowance for 0.25 percentage points of case mix growth, applied by the governor methodology used in the past. A budget for case mix growth is appropriate within the context of the -1% update. Service shifts that result in case mix change reflect real cost differences to hospitals, and to the degree that some hospitals experience increases while others experience decreases, some attempt to keep payments aligned with resource use is warranted. Further, measured case mix depends on coding and documentation efforts at hospitals, and with the prospect of little recognized case mix, some administrators may expect no return on investment for these activities. Given the fact that the Commission has recognized case mix "rebounds" in the past under system case mix governors, hospitals may face an incentive to relax these activities and hope to capture revenue as part of future case mix growth. Both are reasons for a small budget within the overall inpatient revenue to recognize limited case mix changes.

Some have noted that this approach penalizes TPR hospitals because their targets are not case mix adjusted. The size of the proposed case mix budget is similar to the amount of funds scheduled for the ARR seed funding discussed in Recommendation 3 below, which would be

pulled under this recommendation. Hence, the impact of these proposals would be roughly uniform across ARR and TPR facilities.

***Recommendation 2: Apply an update factor of 1.75% for outpatient rates in FY2013.***

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

Traditionally, the update factor has been uniform between inpatient and outpatient services. Under this scenario, a reduction to inpatient rates would apply to outpatient as well. However, in the past, the Commission has provided differential update factors for inpatient and outpatient services. Industry representatives have suggested that outpatient services should be updated by factor cost inflation. The full market basket of 2.59% would provide an overall revenue increase of about 0.3%.

Under the recommended update of 1.75%, the overall revenue increase would be 0% for FY 2013. The recommendation of 1.75% balances a number of factors. First, because of the revenue realignment from inpatient to outpatient centers undertaken for FY2012 and to continue in FY2013, outpatient rates will be higher. Second, given then higher cost sharing on the outpatient side, additional shifts to outpatient are likely to strain patient affordability for outpatient services.

Finally, there is a technical issue to note regarding the implementation of a differential update factor for inpatient and outpatient services. Because a number of ancillary rate centers have both inpatient and outpatient services but only a single unit rate, these centers would produce a rate change that is a weighted average of the inpatient and outpatient shares. However, the charge per case for inpatient services would not then be as low as the targeted rate. If the Commission approves a -1% update factor for the inpatient services and a 1.75% update factor for the outpatient services, the net effect on inpatient services is -0.36% on inpatient charge per case, the component measured under the waiver.

***Recommendation 3: Do not allocate additional ARR seed funds in FY2013.***

As the system attempts to open up additional room under the Medicare waiver test, the time is right to reconsider revenue to be placed into rates in FY2013 for the ARR program. The first year of funding has already been placed into rates, but the second year has not yet been allocated. Given the pressures the system faces under the Medicare waiver, even the small amount associated with the ARR policy implementation represents waiver room that should be preserved. Further, given the need to generate savings under the readmission policy, this loan to

hospitals on top of the incentives provided by allowing the hospitals to retain savings in the first three years of the readmissions program should be a relatively low priority for funding.

The ARR agreements for the repayment of the seed funds calls for repayment of the allocations beginning in the third year of the ARR agreement, but the agreement allows for the possibility that these funds would not have to be repaid if the ARR hospital showed progress under the ARR arrangement. Because this recommendation modifies the agreement for FY2013 funding, we will also amend the agreement to definitively allow hospitals to keep the first year of seed funding without repayment as long as the hospital demonstrates improvement on readmissions in the following three rate years beginning in FY2013.

By not granting these monies in rates in FY2013, the system would save approximately 0.3% under the relative waiver test. The combined actions of a -1% update to inpatient rates, a 1.75% increase to outpatient rates, and canceling the additional ARR funds in rates yields a reduction to inpatient charge per case of -0.60%.

***Recommendation 4: Streamline system controls.***

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

This recommendation requires a number of technical details to be addressed, and staff has met with industry representatives to discuss these issues. If this recommendation is approved, the staff will issue a memorandum clarifying the methodology for implementation, addressing the transition issues from the current system. Note that this proposal is not intended to modify FY2012 methodology and rate orders.

***Recommendation 5: Establish policy for Medicaid assessments***

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

The precise actions to be taken depend on the inpatient and outpatient updates adopted. To the degree that savings are available, the day limits associated with the Medically Needy program should first be addressed. The next priority would be the $24 million in increased assessments, which if put into rates, would cause further deterioration in the waiver. The current staff recommendation should cover the budgetary requirements without further action. Upon final approval of the update factor, the staff will prepare a report for the Commission itemizing the status of funding and recommending any remaining action as necessary. The MHA has suggested that savings under this proposal would exceed those estimated by the staff. Once these estimates are clarified, the staff will present the Commission with options as appropriate.

***Recommendation 6: Revisit the update factor in January 2013***

This action is necessary. All parties have noted the considerable uncertainty around many of the items incorporated into this forecast: the continued effect of short stays, the size of the ARR and TPR effects, the Medicare update and a potential Coding and Documentation adjustment, etc. Revisiting the update in January 2013 would allow the Commission to consider whether the approved update is too severe, or alternatively, whether the adjustment is sufficient to maintain compliance with the waiver based on the best forecast available. In preparing the preliminary recommendation for April 2012, the staff considered a proposal of -1% for both inpatient and outpatient services. Under that proposal, the expected waiver margin would have been 1.38% for FY2013. To balance the concerns of hospital financial performance, the system's waiver performance, and patient affordability, the expected waiver margin for FY 2013 is 0.74% under the current staff proposal.

On April 24, 2012, as the staff prepared this recommendation, CMS published its preliminary rule for the Inpatient Prospective Payment System (IPPS). This proposed rule was published for public comment, and based on its analysis of the public response, the agency will issue a final rule by August 1, 2012. CMS is proposing a combination of policies that will yield an increase of 0.9% for IPPS hospitals nationally in FY2013, beginning October 1, 2012. This number is less than included in the forecast from the CMS Office of the Actuary, which is the basis of the HSCRC waiver forecast. The staff contacted representatives from the Office of the Actuary to understand the relationship between the actuarial forecast and the preliminary rule. CMS had included reductions for coding and documentation adjustments (0.8%) and for outliers (0.9%), among other adjustments, that were not in the actuary's forecast.

Commission action on the update factor policy for FY2013 will come before the Medicare Inpatient Prospective Payment System final rule will be adopted and before the final status of the federal sequester is determined. As noted above, the expected impact of the recommendations from the IPPS preliminary rule would increase Medicare revenue by 0.9% in Federal Fiscal Year 2013 if adopted as proposed. If this rule is adopted as currently stated, Maryland's waiver margin will deteriorate to -0.32% in the absence of further action under the current modeling assumptions.

***Recommendation 7: Updates for non-waiver hospitals at 1.59%.***

The HSCRC sets rates for certain hospitals that are not under the Medicare waiver, and the staff invited comments around this issue. The psychiatric hospitals, in a joint comment letter, requested an update of inflation plus an additional half a percentage point for capital. In the current environment, some expectation for productivity is appropriate given that HSCRC rates are required for private payers for the non-waiver hospitals. The staff recommends 1.59% as an adjustment for inflation less a 1% productivity requirement.

***Recommendation 8: Continue reallocation of the inpatient revenue for FY2013***

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

***Recommendation 9: No ROC Scaling for FY2013 but continue scaling policies already decided for MHAC and QBR.***

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

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

***Recommendation 10: Make no change to the volume adjustment as part of the update factor decision.***

While the staff has been reviewing arguments for the appropriate calculation of volume based on equivalent admissions, we do not believe this is the appropriate time to implement a more aggressive volume adjustment. Because we are still operating under the legislatively established waiver methodology, a decrease in volume would increase the inpatient charge per case by putting revenue back into the system, further exacerbating our deterioration. While payer representatives have made convincing arguments about how to modify the traditional calculation to properly capture volume, this argument has not been broadly debated and vetted. Nor does it protect the system in the event of a volume downturn.

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

***Recommendation 11: Make no change to the differential as part of the update factor decision.***

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

Maryland
Hospital Association

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

April 24, 2012

John M. Colmers
Chairman, HSCRC
Vice President, Health Care Transformation and Strategic Planning
Johns Hopkins Medicine
3910 Keswick Road, Suite N-2200
Baltimore, MD 21211

Dear Chairman Colmers:

APR 25 '12 PM 1:23

On behalf of the 66 members of the Maryland Hospital Association (MHA), we are writing to share our position on the fiscal year 2013 Annual Payment Update for hospitals in Maryland. As you know, the work of the Commission is critical to the viability of Maryland hospitals. In each of the communities they serve, Maryland's hospitals are one of the largest employers, creating billions of dollars of local economic impact even as jobs statewide in other fields were lost to the economic downturn. As we consider the hospital Update for next year, it is essential that Maryland's hospitals be provided with the resources they need not only to take care of people, but also to ensure access to important services by making sure there are enough people to provide and support that care, which at the same time preserves the continuing positive impact that hospitals as employers have on Maryland's economy.

We find ourselves in extraordinary times. In our 40-some year history of unique payment policy, we have never been more challenged to preserve Maryland's waiver from the Medicare program as we are today. In the absence of immediate action, we will lose that waiver, which would have serious consequences for hospitals, insurance companies, other payors and most important, for the people of Maryland. And the challenge comes through no fault of hospitals. Indeed, Maryland's waiver "test" is now so out of date that Commission policies and hospital efforts to do the right things -- observe rather than admit patients, reduce avoidable readmissions to hospitals, and treat people in the community instead of the hospital -- actually hurt our ability to retain our waiver status. And our state's budget challenges, specifically the Medicaid budget shortfall, has been shifted to other payors, further exacerbating our ability to retain our waiver status. Maryland hospitals believe there is no task more important for this Commission and for the state of Maryland than expeditiously approving a hospital update for 2013 and then developing an alternative waiver test that aligns with the goals of today's health care system. The alternative -- losing our waiver -- is an unacceptable option for us all.

At the same time, we ask the Commission to recognize the significant steps the hospital field has already taken toward delivery system reform. Hospitals have rapidly adopted new policies including:

- one day stays, reduced readmissions and total patient revenue bundled payment programs
- quality-based reimbursement
- reimbursement based on the absence of hospital-acquired conditions
- infection reduction due to use of central lines
- infection reduction due to use of catheters
- infection reduction through better hand hygiene
- reductions in rates of falls within hospitals

- more -

- among the lowest rates of early c-sections and inductions without medical indication in the country
- adoption of electronic health information technology
- connectivity among all hospitals in the state through Maryland's health information exchange

And this is just the beginning. Maryland hospitals should be applauded for these accomplishments at a time when Commission-approved rate updates were as much as 40 percent below the actual cost of caring for a patient in Maryland. As we transition to a new waiver test, we must be careful not to "over correct" the system. The most important goal is to develop a new waiver test and for the Commission and Maryland hospitals to succeed in meeting and exceeding that new waiver test.

Because of the very serious condition of Maryland's waiver, and in an effort to facilitate a timely decision at your May meeting, MHA offers the following:

1) **MHA reluctantly accepts the staff recommendation for a *negative* 1.0 percentage point update for inpatient services, contingent upon a market basket increase (2.59 percent) for outpatient hospital services.** Combined, the net update to hospitals totals only 0.3 percent -- basically holding hospital payments to a near "freeze" level. If the negative inpatient update is in response to the condition of the inpatient waiver, there is room for a reasonable outpatient update, which has no effect on the inpatient waiver, to prevent serious harm to hospitals' financial condition. A 2.59 percent outpatient update is reasonable because:

- **It is affordable.** The net inpatient and outpatient rate increase totals only 0.3 percent -- basically a freeze for hospital payments. Because hospital payments account for only 30 percent of total insurance premiums paid by the public, this decision has little, if any, effect on consumers. In fact, it has been the insurance companies that have benefited tremendously in the last two-plus years from lower hospital payment updates and lower hospital use. The result: significant insurance company profits and reserves. See the attached articles highlighting a nearly 40 percent increase in CareFirst reserves since 2008 and a Commonwealth fund study showing that, had minimum loss ratios been in effect a year earlier requiring insurance companies to spend revenues on actual care for their enrollees, insurance companies would have had to return pocketed profits and reserves of $100 million to consumers, with the required Maryland payback being among the highest in the nation.

- **It continues to encourage greater hospital productivity.** A net update of 0.3 percent implies an expected productivity gain from hospitals of nearly 2.5 percent. This would be one of the largest productivity or "policy" adjustment ever made, and nearly equals the reduction of the past three years *combined.*

- **It yields a positive waiver cushion.** Even though the outpatient rate increase for certain ancillary services would lessen the inpatient waiver improvement, the proposed outpatient increase would result in a positive waiver cushion.

- **It is the minimum needed to address hospitals' financial condition.** The Commission's stated target for hospitals' operating margins is 2.75 percent. The attached chart shows Maryland hospitals currently fall well below that level. The proposed net rate update of 0.3 percent means operating margins will fall even further in 2013. The Commission's action, even at this level, will send negative signals to the credit markets, making the cost of

capital even more expensive for Maryland hospitals and further eroding their financial condition. And none of this takes into account the Medicare sequester to take effect January 1, 2013, which will further depress hospital margins by at least 0.4 percentage points.

Support for a *negative* 1.0 percentage point update requires that any statewide inpatient case-mix growth be governed to zero percent for the next year, despite the real cost increases hospitals will face associated with case mix increase. MHA also supports the staff recommendation of re-evaluating the update in six months. At that time, both the case mix decision and MHA's original request for an overall update of 1.34 percentage points should be given full consideration.

2) **MHA supports the staff recommendation not to change the volume adjustment at this time.** We agree that the issue of unnecessary use of care should be addressed, but believe that that more complex issue is best addressed in the context of waiver modernization discussions and aligning incentives in a new system, and not a piece of this short-term update decision.

In addition, MHA offers views on other policy issues presented by Commission staff:

- **MHA supports moving forward promptly with an examination of the appropriate Medicare and Medicaid differential based on current data.** In the interest of advancing the rate update decision and expeditiously developing a new waiver test, MHA agrees with staff that this examination be part of the waiver modernization efforts.

- **MHA opposes the removal of the ARR seed funding of 0.3 percent in inpatient rates.** The Admission-Readmission Revenue (ARR) programs have just recently begun to be implemented, and we have not yet seen data measuring their early results. Since the staff's waiver projection includes an estimated 0.58 percent reduction in the waiver cushion due to an expected 5 percent decline in readmissions, the funding should remain in rates, as hospital contracts with the HSCRC require.

- **MHA supports the need for streamlined controls.** We agree that to effectively monitor compliance with the Maryland portion of the waiver test calculation, final rate orders, or close-to accurate projected rate orders, need to be available as close as possible to July 1 of each year. MHA believes that the delays in issuing rate orders that occurred the last several years were due to policy changes that did not include well-thought-out implementation plans. As a result, HSCRC staff struggled to figure out implementation plans as rate orders were being developed. We are working with HSCRC staff on a number of technical details related to its proposal to base 2013 unit rates, Charge-per-Episode targets, and case-mix weights using calendar year 2011 data, and believe that the decision on the data to be used to ensure the most effective waiver monitoring can be resolved outside of the Annual Payment Update decision. As part of this process, we also believe that it is important that any rate adjustments that are made outside of the Annual Payment Update and full rate reviews be fully transparent and vetted with all stakeholders prior to implementation.

- **MHA supports the priority order recommended by staff for use of the proposed increase in Medicaid assessments and budget savings.** This would include implementation of outpatient and emergency room tiering of rates. It is our belief that Commission action on the fiscal year 2013 update, when combined with its March action on rate re-alignment, will preclude the need for any additional assessments on hospitals or payors for 2013. We have detailed our estimates of the impact of these two Commission actions on the attached schedule.

- **MHA supports the continuation of the inpatient rate reallocation into fiscal year 2013.**

- **MHA supports the staff recommendation on Reasonableness of Charges scaling and quality-based scaling for 2013.** We agree that, as part of the scaling for 2013 and its potential impact on the current waiver test, no lower floor should be placed on total quality scaling to prevent the full impact of quality scaling on hospitals.

These are extremely challenging times for Maryland hospitals and for our decades-old rate-setting system. We urge the Commission to act, but to act carefully to ensure that we do not over correct the system so much as to preclude hospitals from being able to be successful in meeting the early challenges of a new, and profoundly different, waiver test. As always, should you have any questions about any of the items we have included, please contact me at the Association at (410) 379-6200.

Sincerely,

Michael B. Robbins
Senior Vice President/Financial Policy & Advocacy

cc: Commissioners
Patrick Redmon, PhD., Executive Director

Attachments

# CareFirst's cash reserves in D.C. surge

**Washington Business Journal by Ben Fischer, Staff Reporter**

Date: Friday, March 16, 2012, 6:00am EDT - Last Modified: Monday, March 19, 2012, 2:52pm EDT

CareFirst BlueCross BlueShield's cash reserves in D.C. have swelled by 40 percent since 2008, raising the possibility that the District will order the insurer to reduce premiums or return some of the reserves to customers.

CareFirst's nonprofit D.C. subsidiary, Group Hospitalization and Medical Services Inc., finished 2011 with nearly $964 million in its surplus account, according to an annual report filed with regulators March 7.

Those reserves have nearly tripled over the last 10 years while the nonprofit's revenue has not quite doubled. That prompted the city to pass a law in 2008 giving the District the authority to order a spend-down if the reserves grow too big, and city officials said in January they will review the reserves.

If D.C. Insurance Commissioner William White were to order a spend-down, CareFirst's District customers — employers and their workers — could see rate reductions or a slowdown in inflation in premiums as CareFirst spends its reserves instead of collecting more revenue. It is also possible regulators could order customer rebates.

CareFirst is prepared to defend its reserves level, which it says is justified by the increased business uncertainty created by federal health care overhaul efforts.

"The reserves are at the low end of the appropriate range established by CareFirst's board after extensive external actuarial review," said company spokesman Michael Sullivan. "These reserves protect the interest of CareFirst's members. The process that is used to establish reserve ranges has been thoroughly examined by area regulators."

After the D.C. Council passed the law in 2008, White's predecessor, Gennet Purcell, found in a 2010 decision that CareFirst's 2008 reserve level of $686.8 million narrowly fell within an appropriate range, but promised a new review after more of the 2010 federal health care overhaul was implemented.

Consumer advocacy group D.C. Appleseed, which lobbied for the 2008 law, sued over that decision. Its appeal is still pending before the D.C. Court of Appeals. Walter Smith, executive director of D.C. Appleseed, said it's self-evident under the law that CareFirst's reserves are too big.

"I do think we're coming to the end of this long game," Smith said. "I think this insurance commissioner, in the face of this statute, is going to have no choice but to order a fair amount of this reserve spent down."

All insurance companies must hold substantial cash reserves to guard against a sudden, unexpected surge in medical claims — from an epidemic or a terrorist attack, for instance. But if the reserves are too large, a nonprofit insurer such as CareFirst runs the risk of being criticized for hoarding assets while continuing to raise premium rates.

For more than a decade leading up to 2010, health insurance companies across the country regularly raised rates by 10 percent or more, and CareFirst was no different. In some extraordinary cases, the company sought approval for rate hikes of more than 30 percent. However, customers began rationing their own health care use during the recession, and by the end of 2010, insurance inflation had slowed to nearly zero, levels not seen since the early 1990s.

Meanwhile, CareFirst's reserves peaked in 2010 at $969.5 million after a $208 million jump from 2009. In a June 2011 filing with the District, the company attributed the

growth to a surprising decline in medical spending by its customers during the recession and resulting economic stagnation.

In the second half of 2011, the company began offering to renew customer insurance policies with no rate hikes or, in some cases, rate reductions, to prevent further reserve growth, according to its filings.

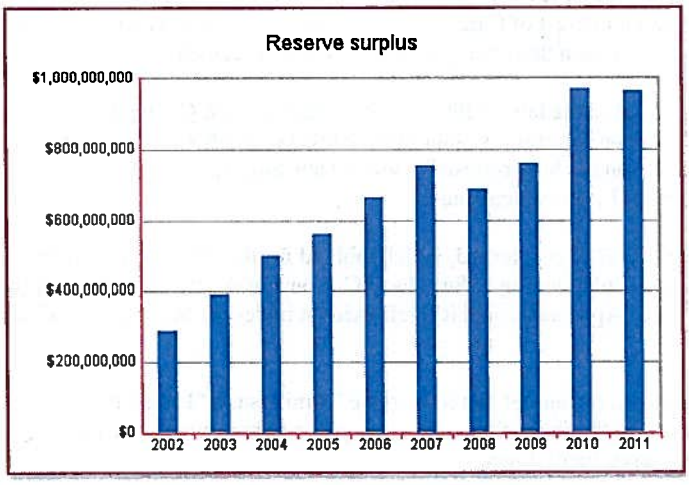
Separately, CareFirst told regulators in its March 7 report that it has stocked away $32.9 million for customer rebates likely to be required under 2010 federal health care reform. Under the law, insurance companies must spend at least 85 percent of their premium revenue on actual medical claims or give a refund. CareFirst says it fell just shy of those thresholds.

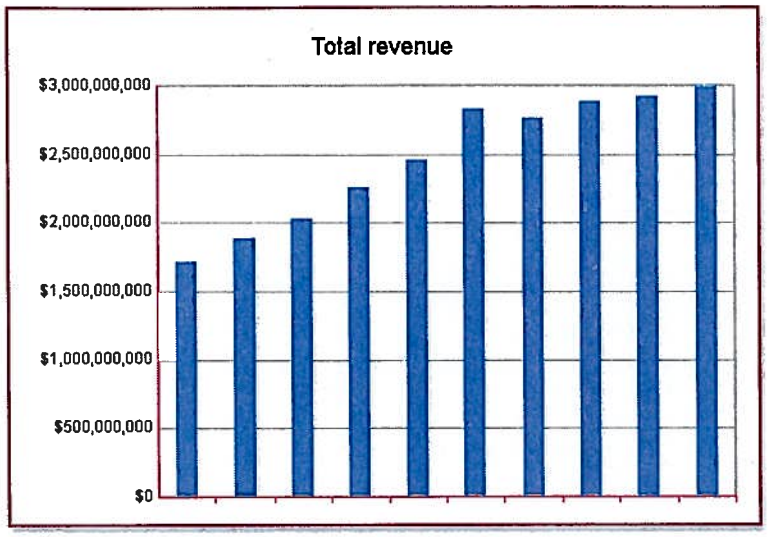
"We are still finalizing … calculations and any associated rebates for 2011," Sullivan said. "Overall, these rebates are expected to be very small — just 0.4 percent of the more than $7 billion in premiums CareFirst received in 2011 is held in reserve for this purpose."

Insurance companies in Maryland and Virginia will be reporting financial data to regulators in April. CareFirst has faced a similar situation in Maryland, where regulators have held its cash reserves to be in an acceptable range.

# In reserve

Group Hospitalization and Medical Services Inc., CareFirst's subsidiary in the District, has added to its reserve account at a pace beyond its business growth in the last decade. Even though insurers are required by law to keep reserves to guard against an unexpected surge in medical claims, some critics accuse the nonprofit of hoarding assets while raising customer premiums.






Online Database by Caspio

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*Source: D.C. Department of Insurance, Securities and Banking*

Ben Fischer covers health care and law.

April 2012

# Issue Brief

Attachment II

# Estimating the Impact of the Medical Loss Ratio Rule: A State-by-State Analysis

Mark A. Hall and Michael J. McCue

**ABSTRACT:** One of the most visible consumer protections in the Patient Protection and Affordable Care Act is the requirement that health insurers pay out at least 80 percent to 85 percent of premium dollars for medical care expenses. Insurers that pay out less than this minimum "medical loss ratio" (MLR) must rebate the difference to their policyholders, starting in 2011. Using insurers' MLR data from 2010, this issue brief estimates the rebates expected in each state if the new rules had been in effect a year earlier. Nationally, consumers would have received almost $2 billion of rebates if the new MLR rules had been in effect in 2010. Almost $1 billion would be in the individual market, where rebates would go to 5.3 million people nationally. Another $1 billion would go to policies covering about 10 million people in the small- and large-group markets.

★ ★ ★ ★ ★

## OVERVIEW

One of the most visible consumer protections in the Patient Protection and Affordable Care Act is the regulation of health insurers' "medical loss ratios" (MLRs). The MLR is a key financial measure that shows the percentage of premium dollars a health insurer pays out for medical care expenses, as opposed to the portion kept for profits, overhead, and sales expenses.[1]

The Affordable Care Act sets minimum MLRs for insurers to reduce administrative costs and thus the ultimate cost of insurance to consumers and the government. Insurers offering comprehensive major medical policies must maintain an MLR of at least 80 percent in the individual and small-group markets and 85 percent in the large-group market.[2] Insurance companies that pay out less than these percentages on medical care and health care quality improvement must rebate the difference to their policyholders.

The new MLR regulations took effect January 1, 2011, and consumers will receive their first rebates in the summer of 2012 from health insurers that fail to meet the requirements. This issue brief uses insurers' data from 2010 to make rough projections about the impact of the MLR rules by estimating the rebates

The mission of The Commonwealth Fund is to promote a high performance health care system. The Fund carries out this mandate by supporting independent research on health care issues and making grants to improve health care practice and policy. Support for this research was provided by The Commonwealth Fund. The views presented here are those of the authors and not necessarily those of The Commonwealth Fund or its directors, officers, or staff.

For more information about this study, please contact:

Mark A. Hall, J.D.
Fred D. and Elizabeth L. Turnage Professor of Law
Wake Forest University School of Law
mhall@wfu.edu

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that would have been expected if the new MLR rules had been in effect a year earlier. These "what if" estimates provide a rough prediction of the impact the MLR rules may have in their first year of application—either by way of requiring rebates or by motivating insurers to reduce rates in order to avoid rebates.

This issue brief first describes the sampling process to determine which insurers offering health insurance policies are projected to owe a rebate and discusses how the rebates are estimated. Next, it presents estimated rebates by state, market segment, and insurer characteristics (e.g. publicly traded vs. nonpublicly traded, nonprofit vs. for-profit, and provider-sponsored vs. non–provider-sponsored). Finally, it discusses the implications and limitations of these findings.

## HOW THIS STUDY WAS CONDUCTED

### Insurer Sample Selection

We included both health and life insurers that offer comprehensive medical coverage and filed their annual financial reports using the National Association of Insurance Commissioners' (NAIC) Supplemental Health Care Exhibit (SHCE).[3] Under the Affordable Care Act, multistate insurers are required to complete the SHCE form for each state in which they have a corporate subsidiary. Thus, our initial sample included 2,633 state insurers that offer comprehensive health insurance as either health or life insurers. The number of members covered by individual, small-group, and large-group policies were 10.1 million, 17.9 million, and 39.6 million, respectively. We excluded property and casualty and fraternal insurers unless they filed as a health insurer.[4,5] Since insurers with enrollment of fewer than 1,000 members have less actuarial "credibility,"—meaning they face greater variability of medical utilization and costs—these insurers are exempted from the MLR rebate regulation.[6] As a result, our reduced sample included the 985 "credible" insurers that covered an average of at least 1,000 members during the calendar year.[7]

Insurers typically have multiple corporate entities within a given state, for different products lines—health maintenance organization (HMO) vs. preferred provider organization (PPO), for example—and for affiliates created or acquired at different times. Therefore, we further aggregated the corporate subsidiaries within each state that belong to a single insurance group.[8] On the basis of corporate affiliation within each state, the total sample size was 648 "credible" insurers who would be subject to the MLR rules (i.e. they averaged at least 1,000 members over the year) if the rules were in effect in 2010. These include 406 insurers offering individual coverage, 396 offering small-group policies, and 421 offering large-group insurance (Exhibit 1). These credible insurers covered about 9.8 million people through individual policies, 17.8 million through small-group policies, and 39.5 million through large-group insurance.

**Exhibit 1. Number of Insurers by Market Segment**

| Types of insurance offered | All individual insurers | Credible* individual insurers | All small-group insurers | Credible* small-group insurers | All large-group insurers | Credible* large-group insurers |
|---|---|---|---|---|---|---|
| Only individual | 918 | 78 | | | | |
| Only small-group | | | 72 | 8 | | |
| Only large-group | | | | | 70 | 24 |
| Only individual and small-group | 156 | 72 | 156 | 20 | | |
| Only individual and large-group | 104 | 10 | | | 104 | 46 |
| Only small- and large-group | | | 77 | 50 | 77 | 48 |
| Individual, small- and large-group | 387 | 246 | 387 | 318 | 387 | 303 |
| Total | 1,565 | 406 | 692 | 396 | 638 | 421 |

* Credible means insurer covers on average at least 1,000 members during the calendar year of 2010 and so would be subject to MLR regulation. Credible insurers operating in more than one market segment may not have credible blocks of business in all market segments. Shown here are insurers with more than 1,000 members in at least one (but not necessarily every) market segment in which they do business.
Source: Authors' analysis.

### Measuring Medical Loss Ratios

The Affordable Care Act requires health insurers to pay a rebate to consumers if they do not comply with the minimum medical loss ratio (MLR) of 80 percent for individual and small-group policies and 85 percent for large-group policies. The law defines small employers as those with 100 or fewer employees, but since many states currently define a small employer as having 50 or fewer employees, states are allowed to maintain that definition until 2016. Medical loss ratios can be calculated in a variety of ways, depending on how the numerator of medical claims and the denominator of total premiums are defined. The Affordable Care Act's rules differ from standard financial ratios in two important ways. First, the MLR numerator for medical claims includes the cost of quality improvement activities and fraud and abuse detection and recovery expenses. Second, the denominator for total premiums subtracts federal and state taxes and assessments. Both these adjustments result in a higher MLR than a standard financial report, which makes it easier for insurers to meet the minimum MLR requirements.

Full calculation of MLR rebates requires several additional adjustments. The first is a "credibility" adjustment based on average membership, to reflect the fact that insurers with smaller enrollments face greater variability of medical utilization and costs. Insurers with fewer than 75,000 members receive a sliding-scale adjustment ranging from 8.3 percent for 1,000 members to no adjustment for 75,000 or more members. Those with fewer than 1,000 members are exempt from the MLR requirement entirely. We make this adjustment using available data but are not able to make two other allowed adjustments: one for high-deductible insurance,[9] and another for amounts that insurers retain to pay claims filed after year-end for medical care delivered during the current year.[10] Despite the limitations, our aggregate findings are broadly consistent with those from other analysts.[11]

For 2011 through 2013, the MLR regulation also allows states to request a waiver from the Department of Health and Human Services for individual health insurance only. To receive this waiver, states must show that complying with the 80 percent MLR would force too many insurers to exit the individual market and leave members with too few insurance options. Seven states have been granted a waiver out of the 17 that applied, with allowable MLRs ranging from 65 percent to 75 percent (Exhibit 2b below). We use these waivered levels to calculate the expected rebates in those particular states.

## ESTIMATING MEDICAL LOSS RATIOS, BY STATE AND MARKET SEGMENT

### Rebates for Individual Coverage

Exhibit 2a shows the number and percentage of insurers per state that would owe a rebate for individual coverage if the MLR rules had been in effect in 2010. The exhibit also indicates the total rebate per state (with top five states bolded), and the estimated median rebate per member among insurers that owe any rebate.[12] For states that have received a waiver, Exhibit 2b shows the reduced minimum MLR and what the median rebates would have been without a waiver.

Nationally, we estimate that insurance consumers in the individual market would have received almost a billion dollars in rebates for 2010 if the new MLR rules had been in effect then. Rebates would go out to 5.3 million of the 10.1 million people covered by this type of insurance, which is 53 percent of the individual market nationally.

At a state level, total estimated rebates would be the highest for Texas and Florida, with $172 million and $109 million in rebates, respectively. Fifteen insurers in Texas and 10 in Florida would owe a rebate in the individual market. The next three states with the highest estimated total rebates are: Illinois ($67 million), Virginia ($50 million), and Missouri ($43 million). Eleven states have at least eight insurers that would pay a rebate (Arizona, Florida, Georgia, Illinois, Michigan, Missouri, North Carolina, Pennsylvania, South Carolina, Tennessee, and Texas). Among these states, the highest rebate per member is North Carolina with $285 and the lowest is Florida with $145 per member.

## Exhibit 2a. Estimated Individual Coverage Rebates and Market Share by State, 2010

| State | Number of insurers owing a rebate | Market share of insurers owing a rebate | Estimated total rebate | Annual rebate per member |
|---|---|---|---|---|
| AK | 1 | 8% | $482,171 | $368 |
| AL | 5 | 9% | $4,478,261 | $278 |
| AR | 5 | 89% | $8,565,831 | $81 |
| AZ | 10 | 95% | $37,263,440 | $153 |
| CA** | 3 | 31% | $36,404,709 | $123 |
| CO | 7 | 37% | $24,384,475 | $219 |
| CT | 5 | 42% | $13,519,939 | $296 |
| DC | 2 | 22% | $487,761 | $111 |
| DE | 2 | 33% | $1,387,174 | $228 |
| **FL** | **10** | **88%** | **$108,879,716** | **$145** |
| GA* | 11 | 45% | $37,110,259 | $233 |
| HI | 0 | 0% | $0 | $0 |
| IA* | 5 | 13% | $4,682,827 | $207 |
| ID | 4 | 53% | $3,943,771 | $58 |
| **IL** | **12** | **92%** | **$67,205,184** | **$159** |
| IN | 6 | 92% | $24,514,821 | $148 |
| KS | 6 | 45% | $10,182,059 | $180 |
| KY* | 4 | 98% | $8,385,536 | $58 |
| LA | 5 | 17% | $9,018,369 | $321 |
| MA | 2 | 5% | $3,139,868 | $603 |
| MD | 5 | 22% | $14,981,817 | $359 |
| ME* | 1 | 34% | $5,436,001 | $425 |
| MI | 9 | 31% | $24,425,945 | $239 |
| MN | 2 | 12% | $7,906,157 | $266 |
| **MO** | **10** | **88%** | **$42,999,105** | **$203** |
| MS | 6 | 79% | $8,416,768 | $134 |
| MT | 4 | 40% | $6,403,902 | $304 |
| NC* | 8 | 15% | $18,144,,817 | $285 |
| ND | 1 | 12% | $1,390,628 | $283 |
| NE | 4 | 27% | $5,460,006 | $185 |
| NH* | 4 | 94% | $7,011,095 | $217 |
| NJ | 1 | 4% | $749,781 | $151 |
| NM | 2 | 4% | $1,045,584 | $439 |
| NV* | 6 | 94% | $11,385,107 | $139 |
| NY | 1 | 3% | $2,192,486 | $661 |
| OH | 6 | 74% | $39,240,643 | $263 |
| OK | 6 | 89% | $16,038,939 | $149 |
| OR | 3 | 14% | $7,811,583 | $298 |
| PA | 10 | 34% | $31,131,338 | $195 |
| RI | 0 | 0% | $0 | $0 |
| SC | 8 | 82% | $34,089,117 | $311 |
| SD | 1 | 4% | $156,414 | $69 |
| TN | 8 | 64% | $25,337,381 | $169 |
| **TX** | **15** | **93%** | **$171,965,247** | **$251** |
| UT | 7 | 36% | $4,156,869 | $81 |
| **VA** | **7** | **88%** | **$50,525,971** | **$181** |
| VT | 0 | 0% | $0 | $0 |
| WA | 3 | 33% | $6,504,757 | $62 |
| WI | 5 | 40% | $10,326,494 | $148 |
| WV | 4 | 80% | $4,373,491 | $251 |
| WY | 2 | 27% | $1,429,844 | $217 |
| US*** | | 53% | $965,073,457 | $183 |

Bolding indicates the five states with the highest total rebate amounts.

* Approved waiver states. ** California data are incomplete. *** Insurers total estimated rebate value is a sum value; rebate per member is total rebates divided by rebate members; market-share percentage is total insured members divided by total insured members receiving a rebate.

Source: Authors' analysis and Center for Consumer Information & Insurance Oversight, Centers for Medicare and Medicaid Services.

**Exhibit 2b. Revised Individual Coverage Rebates in Waiver States**

| Waiver states | Annual rebate per member assuming 80 percent MLR | MLR waiver percentage in 2011 | Revised annual rebate per member |
|---|---|---|---|
| GA | $258 | 70% | $233 |
| IA | $238 | 67% | $207 |
| KY | $61 | 75% | $58 |
| ME | $500 | 65% | $425 |
| NC | $300 | 75% | $285 |
| NH | $235 | 72% | $217 |
| NV | $146 | 75% | $139 |

Source: Authors' analysis.

No insurers in Hawaii, Rhode Island, or Vermont would have been expected to pay a rebate if the new MLR rules had been in effect in 2010. In Idaho and Kentucky, individual insurers owing a rebate would have had the lowest rebates of $58 per member. It is notable that Maine would have made one of the highest rebate amounts of $425 per member even though it received a waiver to phase in its MLR at a rate of 65 percent in the first year. Without the waiver, the median rebate in Maine would have increased to $500 (Exhibit 2b).[13]

In Kentucky, New Hampshire, and West Virginia, only four insurers offering individual insurance policy would have been expected to pay a rebate. Although these individual insurers represent only 15 percent of Kentucky's insurers, 20 percent of New Hampshire's insurers, and 14 percent of West Virginia's insurers (data not shown), these four insurers control 98 percent, 94 percent, and 80 percent of their respective state's individual market share. It is also important to note that both Kentucky and New Hampshire have received a waiver. Kentucky's revised MLR standard of 75 percent reduces its estimated 2010 rebate per member from $61 to $58. New Hampshire's revised MLR standard of 72 percent reduces its estimated 2010 rebate per member from $235 to $217 (Exhibit 2b).

## Rebates for Small-Group Coverage

Exhibit 3 presents estimates of rebates that insurers would be expected to pay for small-group insurance (i.e., employers with 50 or fewer workers), if the new MLR rules had been in effect in 2010. Nationally, small-group insurers would have paid almost a half billion dollars in rebates to 4.3 million small-group members, representing 24 percent of that market segment.

Virginia would have six insurers owing a total of $57 million in rebates and Florida would have four insurers owing $50 million. The next three states with the highest estimated total annual rebates (shown in bold) are: Texas ($43 million), Illinois ($41 million), and Maryland ($38 million). Rebates per member would exceed $300 in California, the District of Columbia, and New Jersey, with the highest rebates estimated for California ($489) and New Jersey ($459). Small-group insurers in 11 states would not have owed any rebate; 17 states would have an estimated rebate per member of less than $100.

In Arizona, Hawaii, and Maryland, at least 40 percent of the small-group insurers would be expected to pay a rebate (data not shown), representing from 18 percent (Hawaii) to 73 percent (Arizona) of the market. Insurers covering at least half of the small-group market share would owe rebates in nine states (Arizona, Florida, Indiana, Maryland, Missouri, Oklahoma, South Carolina, Virginia, and Wisconsin).

## Rebates for Large-Group Coverage

Exhibit 4 presents estimated rebates that insurers would pay for large-group insurance if the new MLR rules had been in effect in 2010. In the aggregate, large-group consumers would have received almost a half billion dollars in rebates—to 5.9 million members, or 15 percent of that market segment.[14] Large-group consumers in Maryland, Florida, and Texas would have received estimated annual rebates in excess of $40 million, while California and New York would receive estimated annual rebates of around $38 million. Rebates per member would have exceeded $300 in Michigan and New Hampshire. Large-group

## Exhibit 3. Estimated Small-Group Coverage Rebates and Market Share by State, 2010

| State | Number of insurers owing a rebate | Market share of insurers owing a rebate | Estimated total rebate | Annual rebate per member |
|---|---|---|---|---|
| AK | 0 | 0% | $0 | $0 |
| AL | 0 | 0% | $0 | $0 |
| AR | 2 | 40% | $2,933,712 | $57 |
| AZ | 8 | 73% | $21,096,518 | $93 |
| CA | 2 | 1% | $2,646,630 | $489 |
| CO | 2 | 12% | $10,258,092 | $290 |
| CT | 2 | 18% | $4,728,265 | $85 |
| DC | 3 | 33% | $14,475,203 | $354 |
| DE | 2 | 28% | $2,192,899 | $141 |
| **FL** | **4** | **74%** | **$50,096,511** | **$76** |
| GA | 7 | 49% | $20,195,670 | $77 |
| HI | 3 | 18% | $3,374,091 | $100 |
| IA | 1 | 10% | $552,383 | $28 |
| ID | 0 | 0% | $0 | $0 |
| **IL** | **9** | **28%** | **$41,330,764** | **$203** |
| IN | 7 | 61% | $12,797,808 | $71 |
| KS | 5 | 15% | $5,963,792 | $165 |
| KY | 0 | 0% | $0 | $0 |
| LA | 1 | 2% | $297,493 | $39 |
| MA | 2 | 3% | $4,172,981 | $226 |
| **MD** | **3** | **62%** | **$38,838,833** | **$151** |
| ME | 1 | 2% | $40,837 | $26 |
| MI | 4 | 5% | $5,475,469 | $210 |
| MN | 0 | 0% | $0 | $0 |
| MO | 7 | 75% | $31,445,646 | $103 |
| MS | 1 | 5% | $919,113 | $139 |
| MT | 3 | 17% | $2,087,163 | $211 |
| NC | 5 | 9% | $3,502,739 | $92 |
| ND | 0 | 0% | $0 | $0 |
| NE | 5 | 44% | $9,133,135 | $216 |
| NH | 1 | 1% | $286,532 | $231 |
| NJ | 1 | 0.3% | $1,398,518 | $459 |
| NM | 3 | 11% | $2,058,046 | $224 |
| NV | 4 | 45% | $8,933,902 | $153 |
| NY | 2 | 2% | $3,763,205 | $123 |
| OH | 6 | 20% | $12,333,990 | $78 |
| OK | 5 | 63% | $20,852,496 | $168 |
| OR | 1 | 4% | $49,342 | $5 |
| PA | 3 | 25% | $5,664,244 | $21 |
| RI | 0 | 0% | $0 | $0 |
| SC | 3 | 57% | $3,911,090 | $35 |
| SD | 0 | 0% | $0 | $0 |
| TN | 4 | 19% | $8,217,820 | $103 |
| **TX** | **10** | **27%** | **$43,160,221** | **$136** |
| UT | 3 | 35% | $3,559,213 | $48 |
| **VA** | **6** | **59%** | **$57,251,964** | **$189** |
| VT | 0 | 0% | $0 | $0 |
| WA | 0 | 0% | $0 | $0 |
| WI | 4 | 51% | $11,184,352 | $63 |
| WV | 1 | 34% | $1,512,451 | $64 |
| WY | 0 | 0% | $0 | $0 |
| US | | 24% | $472,693,133 | $85 |

Bolding indicates the five states with the highest total rebate amounts.

* California data are incomplete. ** Insurers total estimated rebate value is a sum value; rebate per member is total rebates divided by rebate members; market-share percentage is total insured members divided by total insured members receiving a rebate.

Source: Authors' analysis.

## Exhibit 4. Estimated Large-Group Coverage Rebates and Market Share by State, 2010

| State | Number of insurers owing a rebate | Market share of insurers owing a rebate | Estimated total rebate | Annual rebate per member |
|---|---|---|---|---|
| AK | 0 | 0% | $0 | $0 |
| AL | 2 | 5% | $5,466,934 | $218 |
| AR | 1 | 8% | $2,971,794 | $161 |
| AZ | 5 | 15% | $10,745,893 | $154 |
| **CA** | **6** | **44%** | **$39,135,237** | **$94** |
| CO | 3 | 2% | $3,448,936 | $276 |
| CT | 4 | 28% | $6,221,888 | $40 |
| DC | 5 | 26% | $34,711,861 | $260 |
| DE | 3 | 13% | $517,190 | $37 |
| **FL** | **4** | **17%** | **$42,789,749** | **$128** |
| GA | 7 | 18% | $16,981,710 | $89 |
| HI | 1 | 2% | $1,205,585 | $168 |
| IA | 0 | 0% | $0 | $0 |
| ID | 1 | 1% | $164,749 | $63 |
| IL | 6 | 2% | $3,584,636 | $72 |
| IN | 1 | 3% | $1,818,242 | $111 |
| KS | 1 | 1% | $87,899 | $19 |
| KY | 3 | 65% | $11,464,698 | $43 |
| LA | 1 | 0.40% | $81,048 | $81 |
| MA | 3 | 1% | $2,983,405 | $152 |
| **MD** | **6** | **20%** | **$55,509,115** | **$231** |
| ME | 1 | 4% | $450,857 | $58 |
| MI | 2 | 1% | $5,112,485 | $315 |
| MN | 1 | 0.40% | $319,334 | $124 |
| MO | 3 | 11% | $7,756,319 | $112 |
| MS | 2 | 13% | $2,120,132 | $0 |
| MT | 0 | 0% | $0 | $95 |
| NC | 4 | 12% | $11,136,690 | $166 |
| ND | 1 | 2% | $390,156 | $131 |
| NE | 2 | 10% | $1,837,553 | $82 |
| NH | 1 | 1% | $629,610 | $375 |
| NJ | 5 | 19% | $27,427,485 | $116 |
| NM | 0 | 0% | $0 | $0 |
| NV | 2 | 58% | $21,646,775 | $94 |
| **NY** | **7** | **15%** | **$38,119,610** | **$44** |
| OH | 1 | 36% | $24,768,128 | $48 |
| OK | 1 | 2% | $233,112 | $32 |
| OR | 0 | 0% | $0 | $0 |
| PA | 6 | 24% | $35,705,528 | $57 |
| RI | 1 | 5% | $180,950 | $19 |
| SC | 1 | 0% | $176,325 | $176 |
| SD | 0 | 0% | $0 | $0 |
| TN | 4 | 28% | $9,366,399 | $67 |
| **TX** | **7** | **27%** | **$40,213,023** | **$68** |
| UT | 1 | 17% | $277,337 | $3 |
| VA | 6 | 15% | $20,653,608 | $112 |
| VT | 1 | 12% | $395,816 | $42 |
| WA | 1 | 1% | $295,954 | $20 |
| WI | 1 | 15% | $6,198,204 | $38 |
| WV | 1 | 5% | $486,170 | $66 |
| WY | 0 | 0% | $0 | $0 |
| US** | | 15% | $495,788,128 | $72 |

Bolding indicates the five states with the highest total rebate amounts.

* California data are incomplete. ** Insurers total estimated rebate value is a sum value; rebate per member is total rebates divided by rebate members; market-share percentage is total insured members divided by total insured members receiving a rebate.

Source: Authors' analysis.

insurers in Alaska, Iowa, Montana, New Mexico, Oregon, South Dakota, and Wyoming would not have incurred any rebate. In Connecticut, the District of Columbia, Maryland, and New Jersey, more than half of the large-group insurers would pay a rebate (data not shown). In Kentucky and Nevada, large-group insurers that would owe rebates have more than 50 percent of the market share; those in eight other states (California, Connecticut, the District of Columbia, Maryland, Ohio, Pennsylvania, Tennessee, and Texas) that would owe rebates cover 20 percent or more of the market.

## Rebate Estimates by Insurer Characteristics

Exhibit 5 presents the percentage of credible insurers that would be expected to pay a rebate by various insurer characteristics, as well as their median rebate per member.[15] In this exhibit, we treat each corporate entity within a state as a separate insurer—rather than aggregating affiliated subsidiaries into a single insurer—to generate more observations about how each type of corporate entity is managed.

If the new MLR rules were in effect for 2010, insurers that are privately-owned, nonprofit, and provider-sponsored would be substantially less likely than their corporate counterparts to owe rebates in each of the market segments. For some market segments, there are large differences in the likelihood of owing a rebate. Provider-sponsored health plans show the most pronounced difference, perhaps because they are more inclined to favor provider reimbursement over corporate profits. A consistent pattern did not emerge, however, for median rebate amounts among insurers owing any rebate.[16]

## Overall Market in Each State

Exhibit 6 presents estimates for each state across the three market segments combined. In 26 states, at least 20 percent of commercial health insurance consumers would have received rebates for 2010 if the new MLR rules had been in effect that year. Rebates would go to almost half the market or more in Arizona, Florida, Kentucky, Missouri, and Nevada. Overall, in 19 states, nine or more insurers would owe rebates in at least part of the market, with Texas topping the list with 22 rebate insurers.

**Exhibit 5. Estimated Annual Rebates by Insurer Characteristics, 2010**

| | Credible* insurers owing a rebate | Median rebate per member |
|---|---|---|
| **Individual coverage** | | |
| Publicly traded (n=266) | 70%** | $217** |
| Nonpublicly traded (n=263) | 48% | $334 |
| For-profit (n=411) | 70%** | $237** |
| Nonprofit (n=118) | 20% | $107 |
| Non–provider-sponsored (n=499) | 61%** | $230 |
| Provider-sponsored (n=30) | 23% | $174 |
| **Small-group coverage** | | |
| Publicly traded (n=292) | 37%** | $108 |
| Nonpublicly traded (n=275) | 22% | $138 |
| For-profit (n=379) | 39%** | $126 |
| Nonprofit (n=188) | 12% | $78 |
| Non–provider-sponsored (n=500) | 33%** | $119 |
| Provider-sponsored (n=67) | 8% | $92 |
| **Large-group coverage** | | |
| Publicly traded (n=357) | 28%** | $93*** |
| Nonpublicly traded (n=275) | 16% | $162 |
| For-profit (n=420) | 29%** | $101 |
| Nonprofit (n=212) | 10% | $117 |
| Non–provider-sponsored (n=559) | 25%** | $101 |
| Provider-sponsored (n=73) | 5% | $116 |

* Credible means insurer covers on average at least 1,000 members during the calendar year of 2010 and so would be subject to MLR regulation.
** = significant at .01 level. ***= significant at .05 level.
Source: Authors' analysis.

## Exhibit 6. Estimated Market Share and Total Annual Rebate for Insurers Owing Rebate

| State | Number of insurers owing a rebate | Overall % market receiving rebate | Total estimated annual rebate |
|---|---|---|---|
| AK | 1 | 1% | $482,171 |
| AL | 6 | 4% | $9,945,195 |
| AR | 5 | 37% | $14,471,337 |
| AZ | 13 | 52% | $69,105,851 |
| CA* | 8 | 27% | $78,186,576 |
| CO | 9 | 12% | $38,091,504 |
| CT | 7 | 26% | $24,470,092 |
| DC | 5 | 27% | $49,674,824 |
| DE | 5 | 20% | $4,097,263 |
| **FL** | **11** | **47%** | **$201,765,976** |
| GA* | 15 | 32% | $74,287,639 |
| HI | 3 | 6% | $4,579,677 |
| IA* | 6 | 6% | $5,235,210 |
| ID | 5 | 15% | $4,108,520 |
| **IL** | **17** | **21%** | **$112,120,583** |
| IN | 10 | 37% | $39,130,871 |
| KS | 9 | 11% | $16,233,750 |
| KY* | 4 | 55% | $19,850,234 |
| LA | 6 | 5% | $9,396,910 |
| MA | 6 | 2% | $10,296,254 |
| **MD** | **9** | **30%** | **$109,329,765** |
| ME* | 2 | 7% | $5,927,694 |
| MI | 12 | 5% | $35,013,899 |
| MN | 3 | 3% | $8,225,491 |
| MO | 13 | 45% | $82,201,070 |
| MS | 7 | 24% | $11,456,013 |
| MT | 6 | 15% | $8,491,065 |
| NC | 12 | 12% | $ 32,784,247 |
| ND | 2 | 3% | $1,780,784 |
| NE | 7 | 22% | $16,430,694 |
| NH* | 5 | 12% | $7,927,237 |
| NJ | 6 | 11% | $29,575,784 |
| NM | 5 | 4% | $3,103,630 |
| NV* | 8 | 61% | $41,965,783 |
| NY | 7 | 12% | $44,075,301 |
| OH | 11 | 34% | $76,342,761 |
| OK | 10 | 32% | $37,124,548 |
| OR | 4 | 3% | $7,860,925 |
| PA | 15 | 25% | $72,501,110 |
| RI | 1 | 3% | $180,950 |
| SC | 11 | 33% | $38,176,531 |
| SD | 1 | 1% | $156,414 |
| TN | 11 | 32% | $42,921,600 |
| **TX** | **22** | **39%** | **$255,338,491** |
| UT | 9 | 24% | $7,993,419 |
| **VA** | **12** | **37%** | **$128,431,543** |
| VT | 1 | 6% | $395,816 |
| WA | 4 | 6% | $6,800,711 |
| WI | 6 | 26% | $27,709,050 |
| WV | 5 | 21% | $6,372,111 |
| WY | 2 | 7% | $1,429,844 |
| US | | 23% | $1,933,072,547 |

Bolding indicates the five states with the highest total rebate amounts.

* California data are incomplete.

Source: Authors' analysis.

## SUMMARY AND IMPLICATIONS

The new limits on insurers' medical loss ratios in the Affordable Care Act are intended to reduce overhead costs and consequently, the overall costs of health insurance. If the new MLR rules had been effect in 2010, we estimate that insurance consumers would have received close to $2 billion in rebates. These would be spread across 53 percent of the members in the individual market, but only 24 percent and 15 percent of the small- and large-group markets, respectively. This indicates that the new rules have been designed in a way that does not place onerous restrictions on the market as a whole. The law's minimum MLRs were keyed to existing market averages. In addition, the definition of MLR in the law is somewhat more forgiving than prevailing reporting practices. Further, seven states (out of the 17 that applied) have been granted waivers that reduce the target MLRs in their individual markets.

As expected, a greater proportion of consumers in the individual market would expect rebates than would those in the group markets. This reflects the fact that the individual market is held to the same minimum loss ratio as is the small-group market, even though loss ratios in the individual market historically are lower,[17] due in part to higher average sales costs. For consumers who receive rebates, the average amounts could be substantial—often in the $100 to $300 range per person, and occasionally more. Insurers in Texas and Florida are expected to pay over $200 million in rebates in each state, across all three policy types.

Also as expected, a significantly greater proportion of for-profit and publicly traded insurers would owe rebates compared with nonprofit insurers, if the MLR rules had applied in 2010. Notably, few provider-sponsored insurers would owe any rebates, perhaps reflecting their institutional incentive to favor medical claims over corporate profits.

Insurers have had advance notice of the new MLR rules for a year and are expected to change in various ways in anticipation of their effect.[18] Some insurers may reduce their overhead and premiums or increase costs related to improving quality of care to be sure they conform to the MLR minimums. However, others may seek to maximize profits by ensuring that their MLRs do not rise higher than the minimums set by the Affordable Care Act. Moreover, profits are affected both by the MLR and by how much insurance a company sells. To attract more subscribers, pressure on the MLR can thus translate into reduced premiums through reduced medical costs. Regardless of which of these speculative possibilities transpire, it is almost certain that the MLR rules will produce different results in future years than are estimated here for 2010. However, even if rebates dwindle, this analysis indicates that millions of consumers stand to benefit from the new rule's reduction of profits and overhead costs incurred by many insurers.

## NOTES

[1] D. A. Austin and T. L. Hungerford, *The Market Structure of the Health Insurance Industry* (Washington, D.C.: Congressional Research Service, Nov. 17, 2009), available at http://www.fas.org/sgp/crs/misc/R40834.pdf.

[2] Federal Register, Vol. 75, No. 230, Health Insurance Issuers Implementing Medical Loss Ratio (MLR) Requirements Under the Patient Protection and Affordable Care Act, interim final rule for state health plans, Dec. 1, 2010, available at http://edocket.access.gpo.gov/2010/pdf/2010-29596.pdf; and healthcare.gov, "Medical Loss Ratio: Getting Your Money's Worth on Health Insurance," fact sheet, Nov. 22, 2010, available at http://www.healthcare.gov/news/factsheets/2010/11/medical-loss-ratio.html.

[3] In a few instances, we filled in by hand SHCE information missing from the electronic NAIC data set (specifically, for CareFirst, a Blue Cross plan in the District of Columbia, Maryland, and Virginia markets). Still missing are data from many health insurers operating in California. These insurers do not file NAIC forms since they are regulated only by California's Department of Managed Care and not by its Department of Insurance. California health insurers will have to comply with the MLR regulation but are not required to submit the SHCE data electronically to NAIC. Nevertheless, NAIC data do include 56 California life insurers that filed SHCE data, since they are offering health insurance products regulated by California's Department of Insurance.

[4] Under the Affordable Care Act, insurers offering comprehensive medical insurance are required to report their MLR by market segment (individual, small-group and large-group) for each corporate entity in each state in which they are licensed to operate. Nationally, we collected the SHCE form for 2,633 health insurance companies, which do business in different market segments as follows: those offering individual coverage only, 1,342; offering small-group coverage only, 138; offering large-group coverage only, 113; offering individual and small-group coverage only, 226; offering individual and large-group coverage only, 116; offering small- and large-group coverage only, 199; offering coverage in all three markets, 499.

[5] The NAIC requires insurers to report annual financial filings using one of four different forms, called "blanks": Health, Life, Property and Casualty, or Fraternal Blanks. If 95 percent of insurer's premium revenue is from health insurance, an insurer files health insurance blanks (forms). If health insurance accounts for less than 95 percent of premium revenue, the insurer submits the financial blanks associated with the type of license it holds in the state, which can be Life, Property and Casualty, or Fraternal. This analysis is limited to insurers that used the health blank in 2010. This includes 19 property/casualty insurers. However, following the federal regulation, we did not sample property/casualty and fraternal insurers that did not submit the health blank. We also excluded insurers from all U.S. territories including Guam, Puerto Rico and Virgin Islands. For details, see Federal Register, Vol. 75, No. 230, on the interim final rule for the MLR for state health plans, Dec. 1, 2010 (note 2 above).

[6] Following the above MLR regulation (see note 2 above, Federal Register, Vol. 75, No. 230), member is defined as life years or member months divided by 12.

[7] We also dropped one individual insurer that reported a zero value for MLR and another that reported a negative MLR.

[8] Accordingly, throughout the remainder of this brief, "insurer" refers to the affiliated group of corporate entities in each state, unless otherwise noted.

[9] Insurers that receive a credibility adjustment (those with fewer than 75,000 members) and that also offer a high-deductible plan (greater than $2,500) can receive an additional adjustment depending on the deductible size. For example, having a $10,000 deductible will increase a smaller insurer's credibility adjustment by 173.6 percent. This reflects the fact that "catastrophic" coverage has a much lower premium than comprehensive insurance and therefore bears a greater proportionate share of fixed or average overhead costs.

[10] We also are unable to estimate which insurers will use the "dual contract" aggregation rule, which allows them to combine loss experience from two different products that are sold as a bundled product, such as indemnity coverage that "wraps around" an HMO plan to provide out-of-network coverage in "point of service" product.

[11] See, for instance, Memorandum to Kevin McCarty from Sandy Praeger dated June 9, 2011; Consumer Health Insurance Savings under the Medical Loss Ratio Law (U.S. Senate Comm. on Commerce, Science and Transportation, May 2011, http://commerce.senate.gov/public/?a=Files.Serve&File_id=98f51e42-e9ef-441a-a5e3-6bdac44d6a27); U.S. General Accountability Office, Private Health Insurance: Early Indicators Show that Most Insurers Would Have Met or Exceeded New Medical Loss Ratio Standards (Oct. 21, 2011); Jill Herbold, 2010 Commercial health Insurance: Medical Loss Ratios and Illustrative Rebates (Milliman, Feb. 2012). Our total rebate values for small-group and large-group policies may be higher because we included the SHCE fillings that were missing from NAIC's electronic data, for CareFirst Group within the District of Columbia, Maryland, and Virginia markets.

[12] "Member" refers to each person covered by insurance. However, rebates will not necessarily be distributed to members on a per capita basis. Instead, rebates may be allocated differently for family versus single or adult coverage. Also, for employer-sponsored insurance, rebates will be divided between employers and workers in proportion to the share of the premium paid by each.

[13] Massachusetts and New York also show high estimated median rebates but for only a small fraction of the market. These estimates are likely anomalous since they primarily reflect small-indemnity plans owned by much larger insurers, which are used to cover the out-of-network component of HMO "point of service" products. Therefore, it is likely that their loss experience is eligible to be aggregated with that of the larger plan, under the MLR's "dual contract" rule, explained previously.

[14] Our results generally accord with, but are not identical to, similar analyses done by others. For instance, our total rebate value for large-group insurers was $495 million, compared to $526 million from NAIC's analysis (see Sandy Praeger dated June 9, 2011; Consumer Health Insurance Savings under the Medical Loss Ratio Law (U.S. Senate Comm. on Commerce, Science and Transportation, May 2011)). The major differences occurred in four states (Colorado, Georgia, Ohio, and Virginia) where electronic data were missing or incomplete in the NAIC analysis but we were able to obtain more complete information from hard copies or other sources.

[15] The median test was used to test differences in median rebate per member across the three organizational traits and the chi square test was used for the percentage values of the group traits. Insurer characteristics were initially defined by the traits listed on demographic page of their NAIC electronic filing, but for insurers that are subsidiaries of a larger company, the trait is defined by the parent company. Thus, an insurer is defined as nonprofit if it is a subsidiary of a nonprofit health care system, even if the subsidiary is incorporated as a for-profit entity. "Provider-sponsored" insurers are those owned, governed by, or managed jointly with health care systems, community health centers, or physician groups.

[16] One reason publicly traded insurers would owe lower median rebates is that the nonpublicly traded category includes both nonprofits and private for-profits, and the private for-profits would owe much higher median rebates than the other subgroups (data not shown).

[17] Austin and Hungerford, *Market Structure,* 2009.

[18] C. McDonald, *A Practical Guide to Federal Medical Loss Ratio Requirements,* © 2011 by Atlantic Information Services, http://aishealth.com/marketplace/bmlr-enlad.

## ABOUT THE AUTHORS

Mark A. Hall, J.D., is the Fred D. & Elizabeth L. Turnage Professor of Law at the Wake Forest University School of Law. One of the nation's leading scholars in the areas of health care law and policy and bioethics, he is currently engaged in research in the areas of consumer-driven health care, doctor/patient trust, insurance regulation, and genetics. The author or editor of 15 books, Hall also teaches in the MBA program at the Babcock School and is on the research faculty at Wake Forest's Medical School. He regularly consults with government officials, foundations, and think tanks about health care public policy issues. He earned his law degree from the University of Chicago.

Michael J. McCue, D.B.A., is a professor in the department of health administration in the School of Allied Health Professions at Virginia Commonwealth University. He received his doctorate in business administration from the University of Kentucky with a concentration in corporate finance and has conducted several funded studies with Robert E. Hurley, Ph.D., on the financial performance of publicly traded Medicaid health plans.

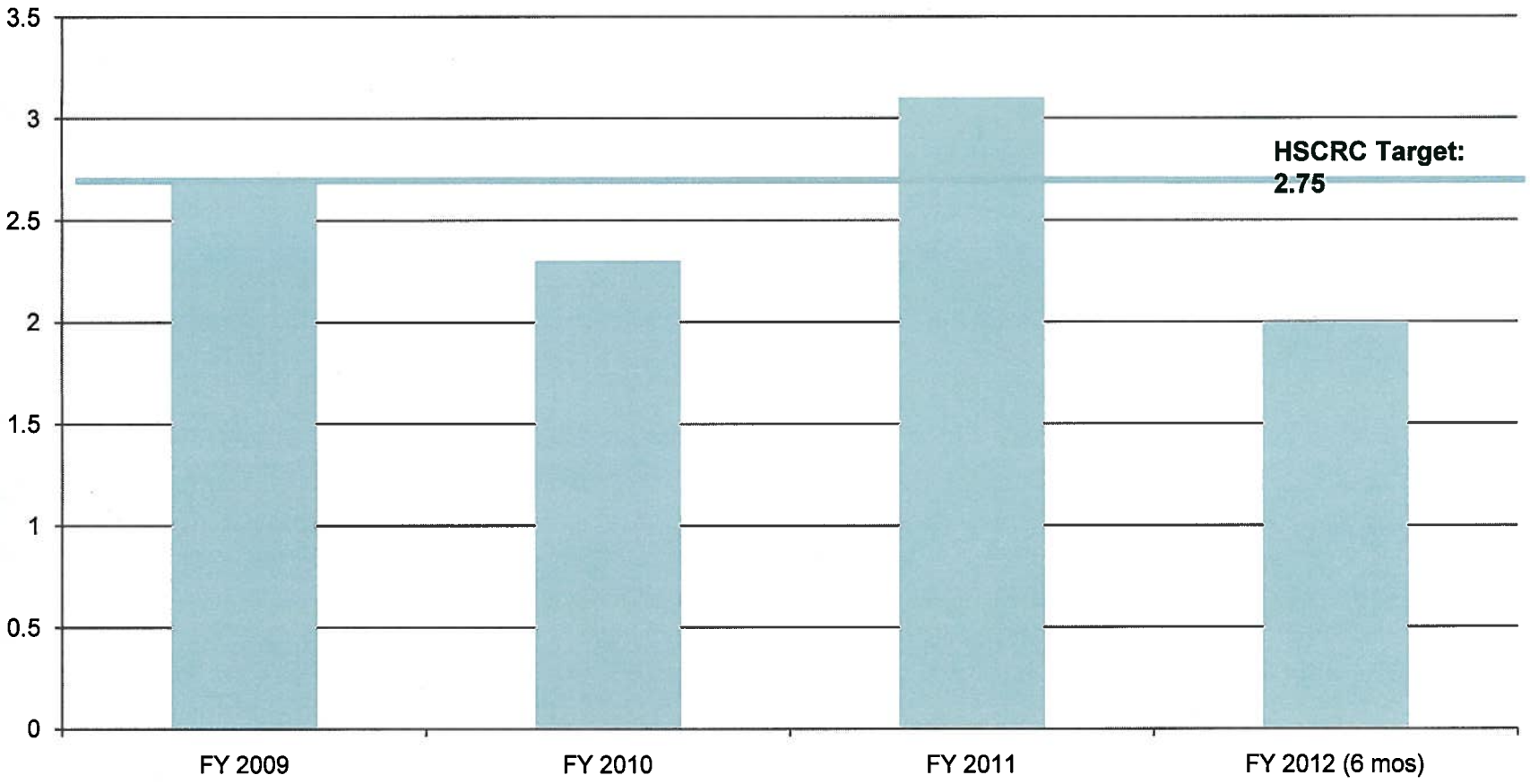
## ACKNOWLEDGEMENT

Xinliang (Albert) Liu, doctoral candidate in the Department of Health Administration at Virginia Commonwealth University, assisted with data analysis for this study.

*Editorial support was provided by Deborah Lorber.*

# Net Operating Margin FY 2009 – FY 2012 (6 months)

Attachment III




Source: Unaudited Financial Conditions

Maryland Hospital Association

Maryland
Hospital Association

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

Attachment IV

# MEDICAID ASSESSMENT ANALYSIS

In the current FY 2013 Medicaid budget, there is a proposed increase in the Medicaid deficit assessment of $24 million, combined with recommended cuts in general funds of $36 million for imposition of Medicaid day limits on the Medically Needy population, $30 million for tiering of rates in outpatient clinics and the emergency room, and (subject to approval of the Budget Reconciliation and Financing Act, or BRFA) $9.1 million for pooling of Disproportionate Share Hospital (DSH) funds. Together, these proposed cuts/assessments total $99.1 million in general funds. Medicaid has informed the HSCRC that it assumed a hospital rate update of 4.13 percent in its budget, and that budget language requires that any savings that result from an update that is below that level can be counted towards the targeted $99.1 million in savings. The HSCRC staff recommendation includes support for implementing the outpatient clinic and emergency room rate tiering. MHA would then estimate the following impact of approving a combined update of 0.3 percent, which includes the negative 1.00 percent inpatient update and 2.59 percent outpatient rate update:

| | |
|---|---|
| Proposed new budget cuts/assessments for fiscal year 2013 | $99,100,000 |
| Less: Savings anticipated from outpatient/emergency rate tiering: | $(30,000,000) |
| Balance remaining | $69,100,000 |
| Less: Savings anticipated from lower-than-budget update (Note 1) | $(42,000,000) |
| Less: Savings anticipated from rate realignment (Note 2) | $(45,000,000) |
| Excess savings potentially available | $(17,900,000) |

**Note 1**: This estimate uses an overall increase of 1.13 percent in rates, including an estimate for potential outpatient case-mix growth. The Medicaid budget currently includes an update budget of 4.13 percent; each 1 percent below that level saves $14 million in general funds (3 percent lower update yields $42,000,000).

**Note 2**: MHA estimates that the rate realignment approved by the Commission at its March meeting lowered Medicaid's baseline charges by about $50 million per year below what would have been used in Medicaid's budget preparation. We estimate that this will reduce Medicaid payments by about $45 million per year in 2013 below its baseline spending included in the approved budget.

HOLY CROSS HOSPITAL

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

*Sent via Email*
April 26, 2012

John M. Colmers, Chairman
Joseph Antos, Ph.D.
George H. Bone, M.D.
Jack C. Keane
Bernadette C. Loftus, M.D.
Thomas R. Mullen
Herbert S. Wong, Ph.D.
Patrick Redmon
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215-2299

Dear Commissioners:

I am writing to you to share Holy Cross Hospital's perspective on the HSCRC's Annual Payment Update for fiscal year 2013 and express our support of the Maryland Hospital Associations' proposal.

We believe the preservation of the Medicare waiver is critically important to the viability of Maryland hospitals while the Commission embarks on developing an alternative waiver test aligned with a modernized approach to managing healthcare costs. We recognize the need for immediate action to ensure the cumulative inpatient rate of growth in Maryland remains below the national average and reluctantly support the measure to institute a negative inpatient update factor of -1.0%. However, we believe there is room for a reasonable market basket update (2.59%) for outpatient services. This proposed outpatient rate adjustment would still produce a positive waiver cushion and an overall rate increase that is consistently flat for fiscal 2013.

More importantly, the outpatient market basket increase will allow us to offset a portion of the inpatient rate decline and provide the essential resources to support established operations. We will still be challenged within this constrained resource environment to develop an achievable operating budget and capital plan to meet the needs of our growing community. We will be reevaluating our proposed budget initiatives for FY 2013 to improve clinical programs and achieve quality outcomes and balance our financial assistance support for the uninsured and underinsured. Holy Cross Hospital has steadily grown its annual charity care commitment from $12.4 million in fiscal 2009 to $19.2 million in fiscal 2011 and our community depends on having these essential services available.

On Monday, April 30, Holy Cross Hospital will open its third health center for the uninsured in Aspen Hill, Maryland, and this will be the second one opened in the past three years. We project we will see over 30,000 patients at the three centers next year, as well as 15,000 patients in our OB/Gyn clinic. We are willing to make these difficult choices with the goal of preserving the Medicare waiver but an overcorrection may place essential services and financial support for the uninsured at risk.

Thank you in advance for your thoughtful consideration.

Sincerely,

Anne D. Gillis
Chief Financial Officer

SAINT AGNES
HOSPITAL

900 Caton Avenue
Baltimore, MD 21229-5201
410.368.6000 phone
www.stagnes.org web

April 20, 2012

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

Dear Dr. Redmon:

Saint Agnes Hospital appreciates the opportunity to comment on the Update Factor Recommendation for FY 2013. Given the challenges our industry currently faces with respect to the deteriorating Medicare waiver, it is important we move cautiously into the next rate year but continue to be sensitive to hospitals' tenuous financial conditions. We would like to address the following items related to the update factor:

**Case-mix Allowance**

We believe it is bad policy to limit total statewide case-mix growth to zero. The allowance for case-mix in hospital charge targets is intended to allow hospitals to receive the resources necessary to account for the additional costs associated with treating higher need patients. During times when the base update more closely reflects factor cost inflation, a stricter case-mix allowance can be managed to by hospitals given the overall growth in their revenue base. However, in an environment when the base update is zero or near zero, hospitals with real increases in case-mix are unable to use base updates to fund the additional costs required to treat increased patient acuity. The rate setting process should provide hospitals with the resources it needs to provide efficient and effective care to treat its patients. The strict imposition of a zero case-mix allowance creates serious barriers to this goal.

In a suppressed economy, healthcare consumers tend to put off much needed healthcare services due to the uncertainty that a down economy creates. We believe this explains why many hospitals have experienced negative case-mix growth during recent periods. As the economy begins to recover, we expect pent-up demand for more involved healthcare services will begin to increase. Hospitals that have experienced case-mix decline during the economic downturn should be allowed to recover in full for the amount of the decline (referred to as case-mix

"rebounding"). This has been the Commission policy since the case-mix governor was employed several years ago and we believe there is no reason to stray away from this policy.

We recommend that Commission staff revisit the case-mix allowance recommendation and consider at least a minimal case-mix allowance for FY 2013. Additionally, consistent with HSCRC policy of the past, "rebound" hospitals should be allowed to realize full case-mix growth from any previous decline.

**Admission Readmission Revenue (ARR) Seed Funding**

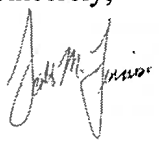
We oppose removal of the year two seed funding for the ARR program. A sound program to reduce readmissions requires a commitment of new resources in program development, staffing, and IT infrastructure. Pulling back on much needed seed funding could seriously jeopardize the stability of readmission reduction programs across the State especially during the fragile early stages of the programs.

**Outpatient Update Factor**

We support the MHA recommendation of a 2.59 percent outpatient update factor. Given the proposed inpatient update factor of negative 1.0 percent, we believe this outpatient factor is affordable and reasonable given several continuous years of base updates below factor cost inflation.

We appreciate your consideration of these comments.

Sincerely,



Scott Furniss
Senior Vice President/CFO

April 20, 2012

Patrick Redmon, PhD
Executive Director
Health Services Cost Review Commission
4106 Patterson Ave.
Baltimore, MD 21215

Dear Dr. Redmon:

This letter is submitted by Sheppard Pratt Health System, Adventist Behavioral Health and Brook Lane Health Services in response to the HSCRC Staff's Update Factor Recommendation for FY2013 dated April 11, 2012. Specifically , this letter addresses Action 7: Updates for non-waiver hospitals.

Due to issues with the waiver test, it is our understanding that the statewide waiver hospitals are recommended to receive a negative 1% inpatient update factor in order to favorably impact the waiver test. Up to full market basket inflation may be provided for outpatient revenues.

As you know, psychiatric hospitals in Maryland are not part of the Medicare waiver and do not enjoy the benefits of the waiver system. We believe it would be inappropriate to treat the psychiatric hospitals in the same manner as hospitals who participate in the waiver for several reasons. Update factors for psychiatric hospitals should not be tied to policy adjustments and decisions which are driven by waiver performance. Additionally, a bifurcated update factor would not be appropriate or equitable for psychiatric hospitals which are over 90% inpatient. For these reasons we respectfully request a base update factor for FY2013 equal to full factor cost inflation.

In past years, the HSCRC Update Factor has included a policy adjustment either reducing or increasing the update factor. The magnitude and reasons for the adjustments have varied over the years. Hospitals have not received a positive policy adjustment since FY2009, when 0.6% was added to rates in an effort to recapitalize the industry. While acute hospitals have an opportunity to request rates for capital funding through a partial application capital policy, psychiatric hospitals must rely on a more subjective case by case approach for capital funding. As a result, we are requesting a 0.5% increase to the base update provision to facilitate much needed recapitalization for Maryland's psychiatric hospitals.

In conclusion, the undersigned psychiatric hospitals request an estimated update factor for FY2013 of 3.09%:

| | |
|---|---|
| Base Market Basket (Estimate) | 2.59% |
| Increase for Capital | 0.50% |
| FY2013 Update Factor (Estimate) | 3.09% |

We appreciate the opportunity for input on this very important matter and we thank you for your consideration of our request.

Please contact Pat Pinkerton at 410-938-3332, Jim Litsinger at 301-251-4592 or Skip Klauka at 301-733-0330 if you would like to discuss this matter further.

Sincerely,

Sheppard Pratt Health System

Adventist Behavioral Health

Floyd E. Klauka Jr., CFO
Brook Lane Health Services

GBMC

John B. Chessare, M.D., MPH, FACHE
*President & CEO*

Office: 443-849-2121
Fax: 443-849-8679
jchessare@gbmc.org

APR 25 '12 PM 1:55

April 23, 2012

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

Dear Dr. Redmon:

GBMC HealthCare Inc. wishes to advise the Health Services Cost Review Commission of its intent to submit an application for State bond funding under the Maryland Hospital Association Hospital Bond Project Review Program. We will be seeking $700,000 in funding to support the expansion and modernization of the Greater Baltimore Medical Center Pharmacy. This project is related to patient care as outlined below. We respectfully request that the Health Services Cost Review Commission confirm that this project will not require a Certificate of Need.

The relevant financial information as required by HSCRC regulation is as follows:

**1) Project Description**

GBMC seeks to improve pharmacy services and the patient and employee safety environment by expanding the current main pharmacy space to meet the increased needs of the service and to accommodate safe storage and preparation of medications. This project will (1) Design and reconstruct an IV room that meets current USP 797 requirements in an improved footprint; (2) Improve the functionality and efficiency of the Pharmacy Department with centralized offices, centralized medication storage, and increased space for medication storage and distribution; and (3) Accommodate new physical infrastructure to incorporate new technology to streamline work flow and reduce waste.

**2) Total Capital Costs**

Total capital costs for the renovation project are currently projected at $10,295,000, including construction costs of $4,500,000.

**3) Sources and Uses of Funds to be Applied to the Project**

The funds for this project will be drawn from donated funds and revenue generated by GBMC HealthCare Inc.

**4) Financing Arrangement**

The multi-year project will be conducted in phases, beginning in FY2013, to provide appropriate budgeting and fundraising timelines. Therefore, no debt servicing is anticipated for this project.

**5) Statement Regarding Increased Patient Charges and Rates**

I verify that this project does not require a total cumulative increase in patient charges or hospital rates of more than $1,500,000 for the capital costs associated with this project.

If you have any questions, or require additional information, please contact Jody Porter, Senior Vice President, Patient Care Services and Chief Nursing Officer, at 443.849.2516 or via e-mail at joporter@gbmc.org.

Thank you for your consideration.

Sincerely,

John B. Chessare, M.D., MPH, FACHE
President & CEO

cc: Jody Porter, Senior Vice President, Patient Care Services
Eric Melchior, Executive Vice President and CFO

JOHNS HOPKINS
MEDICINE

**Ronald R. Peterson**

*President*
**Johns Hopkins Health System**
**The Johns Hopkins Hospital**

*Executive Vice-President*
**Johns Hopkins Medicine**

April 25, 2012

Mr. John M. Colmers
Chairman
HSCRC
4160 Patterson Avenue
Baltimore, MD 21215

Chairman Colmers:

I am writing on behalf of The Johns Hopkins Health System (JHHS) and its member hospitals: The Johns Hopkins Hospital (JHH), Johns Hopkins Bayview Medical Center (JHBMC), Howard County General Hospital (HCGH), and Suburban Hospital (SH) to comment on the FY 2013 Update Factor (UF). Senior management at Hopkins has participated with MHA in the development of the MHA position on the UF. JHHS is totally supportive of the HSCRC rate setting system and the need to protect the Medicare Waiver. We strongly support the position MHA has taken in respect to the rate setting issues we are facing related to the FY 2013 UF.

We agree the preservation of the Medicare Waiver is of paramount importance. We support HSCRC actions to improve the Waiver Test performance. However, there needs to be recognition that the recent deterioration in this test is mainly due to statewide financial issues and not hospital financial performance. FY 2013 will be the fourth year in a row where the hospital industry Update Factor will be significantly below cost inflation. The financial requirements needed to save the Waiver cannot completely be absorbed by the Maryland hospitals. The commercial payors must also participate significantly in the solution.

There are other non revenue producing cost requirements which are essential to the proper management of hospitals such as expanded patient safety programs, health information technology systems and development of core measures. These are necessary programs which may produce cost improvements in the long run but the initial investments are a heavy cost now.

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

The financial condition of Maryland hospitals is under stress due to the need to maintain a highly skilled workforce, introduction of new technologies, increased capital costs and general medical supply and drug cost pressures. These cost pressures are real and not directly controllable by hospital management; they are market driven.

Hospitals are labor and capital intensive organizations.

**Workforce Issues**

The workforce in hospitals is composed of many highly technical components from registered nurses (RN's), medical technologists, pharmacists, information technology specialists and many others. Many hospitals also have union collective bargaining arrangements, and being able to provide market based pay to this very sophisticated workforce is essential.

It is important to keep in mind that most hospitals are the major employer in their communities. Hospitals are a significant economic component of the entire state economy. In order to deal with the 4 years of significant HSCRC rate constraints, at our own hospitals we have needed to drastically constrain replacement and new hiring, as well as postpone development of new programs and creation of new jobs. Going forward, Maryland hospitals, including ours, will likely be required to engage in reductions in force or layoffs which will economically harm their immediate communities and the overall state economy.

**Access to Capital**

Access to capital requires good credit ratings because hospitals must finance a large portion of capital costs through debt. Current Maryland hospital credit ratings are good and stable. This is mainly because the HSCRC system has provided reasonable and predictable rate updates to cover hospital financial requirements. The recent trend in Update Factors is causing concern that Maryland hospitals will not be able to maintain adequate performance to keep stable ratings. If credit ratings deteriorate, capital costs will immediately increase and needed capital projects will be stalled.

At JHH we are opening a major capital project in April 2012 which is a replacement facility for approximately 60% of the patient care services and beds of the hospital. The capital cost of this property is approximately $1.1 billion and will bring $100 million of annual operating costs on to our books. These costs will be offset by a HSCRC rate increase of approximately $30 million. Hospital management will need to achieve $70 million of financial improvement just to cover new capital costs.

Also, we are considering other major capital replacement projects which are needed at JHBMC and SH which may need to be reevaluated or postponed due to the current financial conditions. These community hospitals need to be kept up to date to properly serve their communities.

Finally, we have expressed our concerns over the ability to keep our information technology platforms up to current standards. This is becoming a major portion of our capital investment and is increasingly important to deliver cost effective patient centered care. This investment will result in better population based healthcare and cost efficiency but requires a significant up front capital investment to realize downstream results.

In conclusion, since Maryland is an all payor rate setting state, there needs to be a balanced approach to assure that Maryland hospitals have adequate financial resources to maintain and improve the high quality of patient care the residents of Maryland deserve.

We thank you for your consideration of our comments if any additional information is needed. Please let us know.

Sincerely,

Ronald R. Peterson

cc: Patrick Redmon, Ph.D.
HSCRC – Executive Director

Carmela Coyle
MHA

Meritus Medical Center
11116 Medical Campus Rd
Hagerstown, MD 21742
301.790.8000

April 25, 2012

John M. Colmers, Chairman
Vice President, Health Care
Transformation and Strategic Planning
Johns Hopkins Medicine
3910 Keswick Road, Suite N-2200
Baltimore, MD 21211

RE: Update Factor Recommendation for FY2013



Dear Chairman Colmers:

We are submitting this letter on behalf of Meritus Medical Center in response to Health Services Cost Review Commission (HSCRC) staff's Update Factor Recommendations for FY2013 after consideration of the review and testimony provided during the HSCRC meeting. We have considered staff's recommendations and are providing additional comments by supplement our letter of April 10, 2012.

We have taken each proposal in order of presentation and added our comments:

**Action: Options for inpatient rates**

We support the inclusion of CMI as part of the update factor and support the recommended -1% update factor as a necessary action to be taken at this time.

**Action: Options for outpatient rates**

We support the MHA position for an increase of 2.59%. This outpatient update factor will provide some inflation for hospitals but not impact the current Waiver Test. While we don't believe that higher outpatient rate increases are good policy for the long term, we believe it necessary for the short term.

**Action: Streamline system controls**

We agree with staff's recommendation and support the need for streamlining system controls.

**Action: Establish policy for Medicaid assessments**

We support the staff recommendations and the order of priority for use of the proposed increases in Medicaid assessments.

**Action: Continuation of the inpatient reallocation for FY 2013**

We agree with staff's recommendation, particularly if there is further erosion of the Waiver Test.

**Action: Revisit the update factor in January 2013**

We agree with staff's recommendation to continue the inpatient reallocation to outpatient centers for FY2013.

**Action: Scaling**

We support staff's recommendation regarding the suspension of ROC scaling for FY2013. Longer term the design of a new ROC should be revisited.

**Action: Volume adjustments**

We agree with staff's recommendation as stated for FY2013.

**Action: Differential**

We support the need to promptly examine the level of an appropriate Medicare/Medicaid differential based upon current data identifying costs, use rates, and volumes.

**Additional Comments**

We suggest a new Medicare Waiver methodology be submitted as soon as practical. It will be important to identify the basis of the new Waiver Test and to seek to meet and exceed the new Waiver Test.

We suggest TPR hospitals be recognized as distinct from non-TPR hospitals, as TPR hospitals are focused on population health management and have gone at-risk for case mix and volumes by entering into the TPR agreement. TPR hospitals' needs and interests should be separately recognized.

If you have any questions, please do not hesitate to contract Joe Ross or myself at 301-790-8102 or via e-mail at raymond.grahe@meritushealth.com or joe.ross@meritushealth.com.

Sincerely,

Joseph P. Ross
President and CEO

Sincerely,

Raymond A. Grahe
Senior Vice President and CFO

PENINSULA REGIONAL
MEDICAL CENTER
Part of Peninsula Regional Health System

April 26, 2012

Patrick Redmon, Executive Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Mr. Redmon:

As the sixth largest healthcare system in Maryland and a major trauma service for not only the Eastern Shore but also all travelers and vacationers to our region, we write in support of the Maryland Hospital Association's recommendations.

However, we support these measures with great reluctance. For the past three years, with conservative annual updates, we have responded with cost reduction measures including limits on job growth, new technology acquisition, renovations and service line clinical development. For example, we are currently analyzing our NICU IIIA program, its infrastructure costs and our ability to continue this Level of service. Further, we have not offered a market basket (COLA) adjustment to our 2,900 employees in over three years. The degree of uncertainty and continued instability of our funding process will continue to force us to develop downsizing strategies and/or eliminate, reduce or place on hold clinical programs.

As an economic engine for the Delmarva region, with a downstream spending impact of over $350M annually, the fiscal constraints and potential reductions will impact our general economy. All of this in an environment where 30,000 new Medicaid enrollees are expected to populate our facilities. It is illogical for anyone to expect hospitals to increase capacity and resources absent minimal funding to support new enrollees.

As major healthcare institutions, we have a tradition of responding as team players during fiscally constrained budget periods. However, a fourth budget cycle that reflects significant reductions and a minimal update factor is unacceptable. It is a disservice to our patients and the community at-large.

I thank you for your attention to this most immediate and perilous period in my 35 year history of working with the HSCRC and its staff.

Sincerely,

Peggy Naleppa

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

GARRETT COUNTY MEMORIAL HOSPITAL

April 26, 2012

Mr. Patrick Redmon
Executive Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

**Re: Maryland Hospitals Fiscal Year 2013 Annual Payment Update**

Dear Mr. Redmon:

On behalf of Garrett County Memorial Hospital (GCMH), please accept this letter in reluctant support of the MHA staff recommendation for a *negative* -1.0 percentage point update for inpatient services; contingent upon a market basket increase (2.59 percent) for outpatient hospital services.

As a sole community provider, and sixty miles/one hour away from the next nearest regional hospital, GCMH provides a critical lifeline to the 31,000 residents living in this rural area. Garrett County is one of the few Maryland counties which is consistently classified as a Health Professional Shortage Area (HPSA) and Medically Underserved Area (MUA) due to historically persistent healthcare shortages.

GCMH is the sole provider of ***all*** inpatient and outpatient diagnostic care available to our patients. There are ***no*** free standing labs, radiology centers, walk-in clinics, surgi centers, or Urgi-care centers located within our county. Additionally, economically, Garrett County does not enjoy the same level of per capita income or public transportation as that of most other Maryland jurisdictions. In Garrett County, 42% of the population lives at or below 200% of Federal Poverty. Many of our region's residents still suffer from the persistent financial poverty typical of all regions of Appalachia. Therefore, the lack of any available free standing healthcare alternatives; the inability to access basic healthcare services in any other reachable nearby hospital; and the abject poverty of the region, all combine to severely pressure GCMH to ***remain*** the viable sole source of ALL inpatient and outpatient services where our patients have come to expect the same level of care and treatment be available to them as is available to their urban counterparts.

Additionally, GCMH is also consistently called upon to treat the many part time residents and vacationers who frequent Deep Creek Lake and WISP Ski resort as well as the plethora of other four season recreational opportunities in our county. Therefore, GCMH not only must stand ready to treat the local patient population, but must also meet the standard of care necessary to meet the needs of many who are temporarily in our midst. These expectations/needs must be sustained with adequate rates, or diminution of services will result. And any reduction of services in a small market is exponentially felt by rural market patients compared to their more medically service rich urban counterparts who can usually access the freestanding alternatives to hospitals, which stated above, do not exist here. This sort of access limitation is NOT what Maryland healthcare policy intends, but ***is*** the result of

inadequate update factors; especially to TPR hospitals who cannot make up deficits by increasing volumes.

While we certainly understand the importance of maintaining the waiver, we hope you can understand the critical need for update factors which allow hospitals to at least sustain their current operations in the face of RAC audits, medical inflation, and ongoing demand. This is the sort of mutual respect and partnership the HSCRC and hospitals have shared throughout our collective history together. The last few years updates have been well below medical inflation, and it has been difficult to drive a positive operating margin when expenses are going up faster than revenues. But our hospital has taken every step possible to reduce cost without incurring layoffs. Hiring freezes; furlough time; benefit reductions and take backs; shrunken formulary; attrition based staff reductions; ongoing product evaluations; six-sigma process reviews; below inflation salary adjustments/freezes and the like have all been used to keep expenses in check without hurting employees and/or patient care safety/quality. The proposed MHA update factor plan for FY 13 does nothing to improve hospital's recent history of annual updates well below medical inflation, but it does address the deteriorating waiver issues as well as provides *some* level of protection from a net rate reduction.

Our hospital cannot afford continued "below inflation" rate changes. The local economy relies on the hospital to sustain itself to provide good paying jobs and employee health coverage for spouses and family members. Therefore, flat updates and/or rate reductions not only threaten the fragile and lone healthcare continuum provider in the area, but also threaten the economic stability of individuals and their families. Further, if GCMH loses employees due to job cuts, they would have to move out of the area to find commensurate work. We would then have to incur the additional cost of recruitment and re-training of newly hired staff if we needed them again in the future. The ability to receive sustaining rates in FY13 would help avoid that horrendous cost.

In conclusion, Garrett County Memorial Hospital is unique in its isolation, small market size, level of poverty, and critical medical and economic importance to this rural community. I hope you will agree that the MHA proposal is sensitive to the waiver, the payers, and facilities like ours. I sincerely appreciate your recognition of the devastation any additional cuts would bring to our already fragile system. Thank you for supporting the MHA proposal which at least helps to temporarily assure no diminution of services to our region.

Yours Truly,

Donald P. Battista
President & CEO

llp

MedStar Franklin Square
Medical Center

9000 Franklin Square Drive
Baltimore, Maryland 21237
443-777-6809 PHONE
443-777-7904 FAX
www.medstarfranklin.org

Administration

April 27, 2012

John. M. Colmers, Chairman
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215-2299

Dear Chairman Colmers:

On behalf of MedStar Franklin Square Medical Center (MFSMC), I am writing to share our position on the Fiscal Year 2013 Annual Payment Update for hospitals in Maryland. MFSMC reluctantly supports the HSCRC staff recommendation for a *negative* 1.0 percent update for inpatient services with the adoption of a full market basket increase (2.59 percent) for outpatient hospital services.

MFSMC has been serving our communities for over one hundred years. We provide over $34 million in benefits to our community through charity care, medical education, and various other programs. The communities we serve rely on our services to help those with health concerns and to save lives. It is essential that we have the necessary resources to continue providing that care to the citizens of Baltimore County and the surrounding areas.

In planning our upcoming fiscal year under the proposed assumptions, we will need to thoroughly review all programs and positions. We will likely need to eliminate staffed positions, including those in clinical areas, lower or eliminate pay increases and associate benefits, close programs or reduce hours/services, cut funding for continuing education, and reduce community outreach services such as screenings, support groups and classes.

Although MFSMC has improved productivity over multiple years, this rate decision is likely to result in the reduction and possible elimination of certain programs, further reduction of positions, and limited capital availability for service enhancements. We urge the Commission to act carefully to ensure that we do not put at risk the health and well being of our communities and our associates.

Sincerely,

Robert P. Lally, Jr.
Vice President, CFO

RPL:kad
cc: All Commissioners
Patrick Redmon, Ph.D., Executive Director

OFFICE OF SENIOR VICE PRESIDENT & CFO

Mercy
HEALTH SERVICES

*A University Affiliated Center Conducted by the Sisters of Mercy*

April 27, 2012

Mr. John M. Colmers
Chairman
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215-2299

Dear Chairman Colmers:

I am writing in support of the Maryland Hospital Association ("MHA") compromise position of a negative 1.00% update for inpatient services and an increase of 2.59% for outpatient services. While this proposal will only generate an increase of approximately 0.3% for the industry as a whole, Mercy supports the efforts of the HSCRC to protect the waiver. The alternative proposal of a 1.0% reduction across the board is too severe and will cause irreparable harm to Maryland hospital operating margins, access to capital and bond ratings.

We also agree it is imperative the HSCRC move forward with its plan to draft an alternative waiver proposal that meets the goals of CMS and the citizens of Maryland.

**Impact on operating margins:**

The MHA proposal presents challenges for Mercy and all Maryland hospitals. With costs expected to increase by 2.59% in 2013 and hospital operating margins at 2.1% through January, financial performance for Maryland will be negatively impacted. The MHA proposal will require a productivity improvement of 2.29% and under the insurer proposal, 3.29%. Under each, significant actions will need to be taken throughout the industry such as wage and hiring freezes as well as possible workforce reductions.

Mercy's projected margin for 2012 will be approximately 1.0%. Our margin is below the Maryland average due to the impact of the completion of the Bunting Center, which added $25.0 million of capital costs. The inflationary pressure of 2.59% and the MHA proposed adjustment will seriously impede our ability to operate above breakeven.

301 ST. PAUL PLACE BALTIMORE, MD 21202-2102 (410) 332-9313 FAX (410) 962-1303
TTY (410) 332-9888 E-MAIL jtopper@mdmercy.com

**Bond ratings at risk:**

Under the MHA proposal, we believe all Maryland Hospital bond ratings could face a change to negative outlook as a result of the impact of the rate adjustment and inflationary pressure. This would jeopardize our access to capital and hurt investors who bought Maryland hospital bonds. A more severe adjustment as proposed by the insurers will certainly increase the likelihood of these risks.

Mercy believes and supports the Maryland rate system. We are encouraged by the efforts of the HSCRC to redevelop the all payor system to secure its presence for years to come. However, we urge you to move cautiously and consider the strain you will place on Maryland hospitals under the rate proposals being considered.

Sincerely,

John E. Topper

cc: Commissioners
Patrick Redmon, PhD., Executive Director

**Chet Burrell**
President and Chief Executive Officer

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

CareFirst BlueCross BlueShield

April 27, 2012

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

Dear Commissioners:

This letter addresses two issues that were raised by the HSCRC staff in their April 11, 2012 recommendations regarding the Update Factor for FY 2013. Specifically, it discusses the effects of the HSCRC's one day stay (ODS) policy, and the HSCRC staff's rationale for not eliminating the ODS policy despite its unfavorable impact on the waiver margin, and offers a recommendation; and it reviews and makes a recommendation regarding what Update Factor should be applied to the outpatient charges of hospitals for FY 2013.

## A. The One Day Stay (ODS) Policy

The attached paper, which is entitled "A Discussion of the HSCRC's One Day Stay (ODS) Policy: Its Effect on Patients, Payers, the Medicare Waver and Individual Hospitals," is intended to provide you with a detailed description of the features, effects, and implications of the ODS policy. This paper suggests that the ODS policy provides no demonstrable benefits to patients; produces no cost reductions for the payers; causes a substantial erosion of the Medicare margin; provides an inappropriate level of financial relief to hospitals subject to Medicare's RAC audits that have an especially high level of unnecessary one day stays; unfairly saddles other hospitals (especially the TPR hospitals) that have not created the one day stay problem with an Update Factor that has to be depressed because of the planned continuation of the ODS policy; and, finally, makes no contribution to the development of a population-based hospital cost control program that could be the basis of a revised Medicare waiver test.

After reviewing these issues and consequences, the attached paper reviews the HSCRC's staff's assumptions and rationale for maintaining the ODS policy. We agree that one day stays should not be included in the HSCRC's readmission program (the "ARR"), but we do not accept the staff's assumption that eliminating the ODS policy would require one day stays to be included in the ARR.

Instead, we suggest that the ODS policy should be eliminated, that the one day stays should be subjected to per case DRG payment constraints, and that the admissions and readmissions of the ARR should remain as they are currently defined with revised episode weights. In short, we find no strategic, conceptual or technical reasons that justify the continuation of the ODS policy.

**B. The Update Factor for Outpatient Services for FY 2013**

In our testimony of April 11, 2012 we showed that, for many outpatient services, CareFirst's payments to hospitals are well in excess of our payments to independent providers of the same service. We also showed that the volume of hospital outpatient services is escalating rapidly, with the effect of driving up outpatient costs by double-digit amounts. This has a negative impact on members through higher out-of-pocket costs associated with these outpatient services.

We believe that the use of significantly different update factors for inpatient and outpatient services would result in price discrimination—i.e., some outpatient services would have substantially higher operating margins than the inpatient services. This result is inconsistent with the HSCRC's statutory mandate to set rates without undue discrimination between classes of purchasers and would expose the HSCRC to legal challenge on this matter.

For these reasons, we propose that the inpatient update factor of -1.0% that was proposed by the HSCRC staff should also be applied to outpatient services.

Thank you for this opportunity to comment on the One Day Stay policy and the Update Factors for FY 2013.

Sincerely,

Chet Burrell
President and Chief Executive Officer

**A Discussion of the HSCRC's One Day Stay (ODS) Inlier Policy:**
**Its Effects on Patients, Payers,**
**the Medicare Waiver and Individual Hospitals**

**Presented to the HSCRC**
**by**
**CareFirst BCBS**
**April 27, 2012**

## Executive Summary

This paper examines the HSCRC's One Day Stay (ODS) policy, which excludes one day stay patients from the HSCRC's charge per case (CPC) and Admission/Readmission Revenue (ARR) systems, and provides comments regarding its manifold negative effects. The ODS policy provides no demonstrable benefits to patients; saves no money; materially damages the waiver margin; rewards hospitals with the highest percentage of one day stays; penalizes many hospitals—including, most especially, the "Total Patient Revenue" (TPR) hospitals that are supposed to be a foundational component of the State's anticipated application to CMMI for a new waiver test; and makes no contribution to the establishment of a population-based approach to hospital cost containment.

In particular, this paper quantifies the influence of the ODS policy on the FY 2011 decline in discharges from Maryland hospitals; explains the change in the financial incentives of hospitals that was created by the ODS policy; discusses the impetus that the Medicare RAC initiative has given to ODS reductions elsewhere in the U.S. and in Maryland; describes the manner in which the ODS policy insulates Maryland hospitals from the payment reductions that would otherwise accompany the RAC audits and, in the process, reduces the Medicare waiver margin; and discriminates against hospitals (especially the TPR hospitals) that did not create the ODS problem by imposing on them a depressed Update Factor that is necessary to offset the effects of the ODS policy.

The paper specifically reviews the effects of the ODS policy on patients, on the payers, on the Medicare waiver, and on individual hospitals. It also considers the HSCRC staff's reasons for maintaining the ODS policy—in particular, the assumption that the elimination of the ODS policy would require the one day stay cases to be included in the ARR program. The staff's view is that including one day cases in the ARR "raises the possibility of unwarranted ARR rewards for further reductions in short stay cases." We suggest that the ODS policy could be eliminated, one day stay cases could be re-established as a part of the CPC system (with revised episode weights) and the ARR program could be limited (as it is now) to inpatient cases other than one day stays. This approach would be revenue-neutral to the hospitals, would eliminate most of the detrimental effects of the ODS policy on the waiver margin, would reestablish the efficacy of the RAC audits, and would eliminate the discriminatory Update Factor policies that issue from the continuation of the ODS policy.

In sum, we believe that the ODS policy has no strategic, conceptual or practical value, that it has a wide range of undesirable effects, and that it can and should be eliminated in the manner that we suggest in the attached paper.

* * * * * * * * *

**A Discussion of the HSCRC's One Day Stay (ODS) Inlier Policy: Its Effects on Patients, Payers, the Medicare Waiver and Individual Hospitals**

---

**Presented to the HSCRC**
**by**
**CareFirst BCBS**
**April 27, 2012**

The HSCRC's One Day Stay (ODS) policy, which excludes one day stay patients from the HSCRC's charge per case (CPC) and Admission/Readmission revenue (ARR) programs, represents a fundamental change in the way the HSCRC regulates the reimbursement of inpatients who have one day lengths of stay. In conjunction with the Medicare initiative (i.e., the RAC audits) to review the medical necessity of selected Medicare admissions, the HSCRC's ODS policy provides strong incentives for Maryland hospitals to treat patients who would previously have been admitted for a one day stay on an outpatient basis as an "observation case." Unfortunately, the ODS policy has a range of unfortunate effects. As we will show in this paper, the ODS policy saves no money, materially damages the waiver margin, rewards hospitals with the highest percentage of one day stays and penalizes those hospitals—including, most especially, the "Total Patient Revenue" (TPR) hospitals that are supposed to be a foundational component of the anticipated application to CMMI for a new waiver test based on a population-based approach to hospital cost containment.

In the remaining sections of this paper, we will present the reasons that underlie these criticisms and make some recommendations about the way in which the HSCRC could eliminate the undesirable impacts of the ODS policy in a technically feasible way.

## A. The Recent Decline in Admissions to Maryland Hospitals and Its Implications for the Medicare Waiver

In Schedule 1, we show the decline in Maryland hospital discharges from FY 2010 to FY 2011. In this period, Maryland's inpatient discharges declined by 30,044 (-3.96%), and, of these discharges, 21,169 (i.e., 21,169/30,044 = 0.705 = 70.5%) were one day stays. Therefore, it is clear that the ODS policy is the primary reason for the recent and continuing decline in hospital discharges in Maryland.

**Schedule 1**
**ODS and CPC Discharges FY 2011 vs. FY 2010**

| Discharge Category | FY 2010 | FY 2011 | Difference | % Change | % Difference |
|---|---|---|---|---|---|
| | | | | | |
| ODSs | 153,602 | 132,433 | (21,169) | | 70.5 |
| CPC | 605,828 | 596,953 | (8,875) | | 29.5 |
| **Total** | **759,430** | **729,386** | **(30,044)** | **(3.96%)** | **100.0** |

As will be explained below, this decline in admissions has significantly eroded the Medicare waiver margin because, under the ODS policy, the HSCRC does not remove the difference between the Allowable Charges and the actual charges for one day stays from the inpatient Allowable Charges of the hospitals. These differences are merely reallocated to the remaining inpatient cases. The effect of keeping these differential charges in the inpatient rate base, and dividing the remaining total Allowable Charges of the hospitals by their reduced number of inpatient cases, is to drive up the Allowable Charge per Case and, thereby, to erode our margin under the existing Medicare per case waiver test.

## B. The Financial Incentives of the CPC System

Under the CPC system, before it was modified to eliminate the ODS cases, almost all one day stay cases had Allowable Charges that exceeded their actual charges. This excess of Allowable Charges over actual charges made the provision of inpatient services to one day stay cases highly profitable. As shown in the example that is presented in Schedule 2, the actual charge per case for an illustrative ODS patient was $7,077 and these actual charges were far less than the Allowable Charges of $11,603 that would have been permitted under the CPC system. The $4,526 difference between the Allowable Charges and the actual charges would have been available to the hospital that treated this case and would have been billed to other patients. This CPC policy, which applied to all payers and encouraged the Maryland hospitals to admit large numbers of ODS cases, probably contributed heavily to the fact that Maryland has a disproportionately high percentage of ODS cases relative to the rest of the U.S. (where the IPPS, which includes similar incentives, applies only to Medicare cases). In addition, the effect of admitting a relatively large number of one day stay cases, who have relatively low resource needs, was to artificially depress the average payment per case in Maryland hospitals, and to artificially increase our waiver margin on the Medicare per case test.

The Medicare IPPS (inpatient prospective payment system) provides the hospitals that are located outside of Maryland with financial incentives to admit one day stay cases that are substantially the same as those that were provided to Maryland hospitals by the HSCRC's CPC system. However, under the Medicare IPPS, hospitals that provide inpatient services to patients who could have been treated as outpatients are at risk for payment reductions and related penalties through the RAC audit program. The RAC program is reducing Medicare's number of one day stays and is also reducing the payments associated with them. The Maryland hospitals are not exempt from the RAC audits. Therefore, they have a twofold impetus to reduce their number of one day stays: first, they want to reduce their vulnerability to the RAC audits and the associated payment reductions; and, second, the HSCRC's ODS policy makes one day stay reductions financially neutral to the hospital by leaving the difference between the Allowable Charges and the actual charges of the one day stays in the inpatient rate base.

## C. The Change in the Reimbursement of One Day Stays Introduced by the ODS Policy

Prior to the establishment of the ODS policy, patients with a one day stay were typically included in the HSCRC's charge per case (CPC) system. Under the CPC, the ODS patient was classified by APR DRG and severity level. For illustrative purposes, we present in Schedule 2 an example of a patient who was classified into APR DRG #791 ("OR Procedures for Other Complications or Treatment") with a Severity Level = 1. This patient's assumed charge data are also presented in Schedule 2.

**Schedule 2**
**Assumed APR DRG and Charge Data**
**For a One Day Stay Patient**

APR-DRG #791 ("OR Procedures for Other Complications or Treatment Severity Class: #1" APR DRG Relative Weight = 0.966940

**Charges:**

| | |
|---|---|
| Daily Care | $933 |
| OR | $3,012 |
| Drugs | $660 |
| Laboratory | $97 |
| Supplies | $2,375 |
| **Total:** | **$7,077** |

The CPC system assigned a relative weight to each APR DRG and severity class. In Schedule 2, we show that the relative weight of 0.966940 was assigned to APR DRG #791, Severity Class 1. The CPC system also establishes a "Standard Rate" for each hospital. For the patient whose APR DRG and charge data are presented on Schedule 2, we will assume that the hospital's Standard Rate was $12,000. Under the CPC system, the Allowable Charges for a patient are equal to the Standard Rate multiplied by the APR DRG/Severity Class weight. In our example, the Allowable Charges for the patient would have been calculated as $11,603:

$$\$11,603 = \$12,000 \times 0.966940$$

At the close of each fiscal year, the total inpatient Allowable Charges of a hospital equal the sum of the Allowable Charges of all of the patients who were covered by the CPC system adjusted to reflect Inlier and Outlier adjustments. These adjustments are typically less than two percent (2%) of the Allowable Charges of the hospitals and are not relevant to this discussion of the effects of the ODS policy. The hospital's total inpatient Allowable Charges (inclusive of the Inlier and Outlier adjustments) represent the total amount that the hospital was authorized to charge for inpatient services during that fiscal year. Under the CPC methodology, the patient whose APR DRG and charge data are

presented on Schedule 2 would have contributed $11,603 to the hospital's Allowable Charges in the particular fiscal year.

It is important to note that the charge information presented in Schedule 2, and the associated calculations and observations, are fictitious but we believe them to be accurate in their depiction of the general implications of the ODS policy.

The HSCRC's introduction of the ODS policy in FY 2010 altered the CPC methodology that was described above in a significant way. Specifically, under the ODS policy, patients with a one day stay are no longer covered by the CPC system. Instead, the Allowable Charges for one day stay patients are now defined as being equal to their actual charges. For example, the Allowable Charges for the patient in Schedule 2 would be equal to his/her actual charges of $7,077. Under the new policy, the actual charges for this patient would be added to the actual charges of all of the other ODS patients; and the sum of the charges for the ODS patients would then be added to the Allowable Charges of the inpatients still covered by the CPC system to determine the hospital's total Allowed Charges for inpatient care.

These ODS-related adjustments and their implications are further discussed in the next section.

## D. The Effects of the ODS Policy on the Reclassification of Formerly One Day Stays to Observation Status

When the ODS policy was implemented, the Allowable Charges of the hospitals for ODS cases were broken down into two parts:

- The actual aggregate charges of the one day stay cases; and
- The difference between the aggregated Allowable Charges and the aggregated actual charges of the one day stay cases.

We will refer to the combination of these two components of Allowable Charges as the "Rate Capacity" of the ODS cases.

We can illustrate the differentiation of the Rate Capacity of the hospitals by referring back to Schedule 2. In that instance, the patient would have contributed $7,077 (i.e., his/her actual charges) to the first component of the hospital's Rate Capacity; and $4,526 (i.e., the difference between his/her Allowable Charges of $11,603 and his/her actual charges $7,077) to the second component of the hospital's Rate Capacity. In combination, the patient in Schedule 2 would have contributed $11,603 to the hospital's total Rate Capacity. We shall refer to the $4,526 difference between the Allowable Charges of $11,603 and the actual charges of $7,077 of the patient illustrated in Schedule 2 as that patient's contribution to the "Unused Rate Capacity" of the one day stay cases of the hospital.

Under the HSCRC's ODS policy, the Unused Rate Capacity of all one day stay patients in the "Base Year" (i.e., FY 2009) is totaled and the resulting aggregate Unused Rate Capacity is added back to the Allowable Charges of the patients who are covered by the CPC system—i.e., those inpatients with a length of stay of two days or more. This policy means that a hospital operating under the ODS policy does not lose any Allowable Charges when it redirects or reclassifies patients who were previously treated as one day stay patients in its inpatient service to observation status in its outpatient service.

Under the RAC program, the RAC auditors who are contracted with Medicare review the medical necessity of the one day stays of Medicare beneficiaries at IPPS hospitals elsewhere in the U.S. and at hospitals that are covered by the HSCRC system. Typically, at least some of these one day stays are found to have not been medically necessary admissions. In these instances, the hospitals that have undergone the RAC audits are subject to paybacks and, in some cases, associated penalties. The RAC audits give hospitals elsewhere in the U.S. strong financial incentives to redirect their one day stay cases to outpatient care even though the outpatient payments they receive are less than their inpatient payments for such cases because they do not want to be liable for the associated penalties. In Maryland, the HSCRC's ODS policy gives the hospitals a doubly powerful inducement to redirect their ODS cases to outpatient care because this practice reduces their vulnerability to the RAC audits without reducing their total Allowable Charges.

It is important to emphasize that the HSCRC's ODS policy provides no savings to patients, the payers or the public because the redirection of these ODS cases from the inpatient setting to the outpatient setting leaves the Allowable Charges of the hospitals virtually unaffected by these changes. Therefore, the ODS policy is irrelevant to the real cost containment measures that might be required by a new PMPM Medicare waiver test. Specifically, if all of the payments remain the same, there is no reduction in total costs on a PMPM basis associated with the shift in cases from inpatient to outpatient care. These observations are further elaborated in the following sections.

## E. The Effects of the ODS Policy on Patients

The ODS policy provides no apparent financial benefit for patients. In order to illustrate this point, we shall make further use of Schedule 2 to demonstrate the way in which the charges for our assumed patient would be affected if he/she had been treated as an outpatient instead of as a one day stay at the hospital.

The APR DRG (i.e., #791) that was assigned to the patient in Schedule 2 was determined by the operating room (OR) procedure that was performed. If the patient had received the same OR service as an outpatient, the OR charge (i.e., $3,012) and the related drug ($660), laboratory ($97) and supply charges ($2,375) shown in Schedule 2 would not have changed because the same services would have been provided and the charges for these ancillary services would have been the same for inpatients and outpatients. The only charge that would have changed is the daily care charge ($933), which would have been replaced by another facility charge, presumably for observation services.

It is not practicable to do a study of the relative level of daily care charges of one day stay patients versus the charges for observation services of outpatients whose services might have been provided as inpatient care. However, these charges are likely to be very similar because the level of nursing care required by the patient in Schedule 2 would presumably have been the same whether the operation was provided on an inpatient or outpatient basis. The HSCRC rate setting system is cost-based, so it is reasonable to assume that the daily patient care charge ($933) would be approximately equal to the observation service charge that patient would have been billed if he/she had been treated on an outpatient basis. Therefore, we conclude that there are no demonstrable savings to a self-pay patient whose care is redirected from a one day inpatient stay to outpatient care. For insured patients, including those covered by medicare and by private health plans, the redirection of services from inpatient to outpatient care may impose higher costs because outpatient services often require higher patient payments for coinsurance, deductibles, etc.

Given these observations, we believe that it is reasonable to conclude that the ODS policy has no demonstrable benefits to patients.

## E. The Effects of the ODS Policy on Payers

In the Medicare Inpatient Prospective payment System (IPPS), the redirection of a one day stay case to outpatient care provides substantial savings to the Medicare program because the inpatient payment that Medicare would make as a per case DRG payment is replaced by the outpatient fees paid for the patient's outpatient care. The outpatient payments are generally much lower than the inpatient payments. The savings, based on Maryland data, are typically in the range of approximately 40-50% of the DRG rate.

Under the HSCRC's ODS policy, the situation is very different. In the Base Year, the potential savings of redirecting ODS cases to outpatient care were approximately equal to the difference between:

- The hospital's Allowable Charges for the patient (the counterpart of the Medicare DRG rate); and
- The hospital's actual charges for the patient.

In Section D, we termed this difference—when aggregated over all of the one day stay cases of the hospital—the Unused Rate Capacity of the ODS cases. In that section, we underscored the fact that, under the ODS policy, this amount was added back to the Allowable Charges of the patients who are still covered by the CPC system (i.e., those patients with a length of stay of two days or greater). This adjustment to the inpatient rates of the hospital allocated all the potential savings associated with the redirection of ODS cases to outpatient care to the hospitals.

Thus, the ODS provides no demonstrable savings to patients, the payers or the public in conjunction with the redirection of one day stay cases from inpatient to

outpatient care. As previously shown, if the patient who was the topic of Schedule 2 had been redirected to outpatient care, the patient's insurer would have paid the same amount (i.e., the patient's $7,077 in actual charges) or very close to it whether the patient had been treated as an inpatient or as an outpatient. In addition, the difference (i.e., $4,526) between the Allowed Charges of $11,603 and the actual charges of $7,077 would have remained with the hospital to be billed to other patients. Therefore, under the ODS, there are no savings related to the redirection of one day cases to outpatient care.

## F. The Effects of the ODS Policy on the Waiver

The HSCRC staff has estimated that the ODS policy will result in an erosion of the waiver margin by 3% in FY 2012 and by another 3% in FY 2013. We believe this estimate may be somewhat overstated, but we agree with the staff's finding that the ODS policy has eroded and will continue to erode the waiver margin to a substantial degree. In fact, we believe that the ODS policy will have an injurious effect on the waiver margin that will exceed the negative impact of the Medicaid assessments.

## G. The HSCRC Staff's Proposals to Limit the Erosion of the Waiver Margin and their Implications for Future Updates

Instead of proposing to eliminate the ODS policy, and to remove its noxious effects on the waiver margin, the HSCRC staff has proposed two approaches to maintaining the waiver margin that would keep the ODS policy in place:

- Implement an inpatient update factor of -1.0%; and
- Reallocate approximately 3% of inpatient charges to outpatient services.

We will term a reallocation of Medicare inpatient charges to the charges for other services a "Charge Shift". Charge Shifts, as defined here, include the reallocation of inpatient to outpatient charges, increases in the Medicare differential and similar policy action.

The HSCRC staff projects that, in FY 2013, the combined effect of the ODS policy and the readmission initiative (the ARR) will be to erode the waiver margin by approximately 3.58%. Furthermore, it is reasonable to project that the ODS policy and the ARR (which is likely to grow in its negative impact on the waiver while the effects of the ODS policy subside) will continue to erode the waiver margin by the same amount in the succeeding year and that Medicare payments per case will increase by approximately 1%. Given these proposed approaches and the related observations, it is reasonable to ask the following important question "What do these projections imply for the Update for FY 2014?" We believe that this question is answered below.

In the absence of further Charge Shifts, the waiver margin will be maintained (but not improved) with an Update Factor of -2.58% in FY 2013 which, in the absence of Charge Shifts, would apply to inpatient and outpatient services:

| | |
|---|---|
| Waiver Erosion Due to ODS and ARR Policies | (3.58%) |
| Medicare Update | 1.00% |
| HSCRC Update Needed to Maintain the Waiver Margin | (2.58%) |

In FY 2013, the aggregate charges of the Maryland hospitals will amount to approximately $14 billion. Thus a negative Update of -0.2.58% will require the total charges of the hospitals to be reduced by approximately $361 million:

$14 billion x .0258 = $361 million

In FY 2014, another negative Update Factor of approximately 2.58% would be needed and would further reduce the total charges of the hospitals by another $361 million or a similar amount. These arguably draconian reductions would have highly discriminatory and unfair effects on particular hospitals. These effects are explained below.

## H. The Effect of the ODS Policy on Hospitals

We have already noted the potential of the ODS policy to limit the impact of the Medicare RAC audits on the Allowable Charges of the hospitals. Specifically, Maryland hospitals who respond aggressively to the financial incentives of the ODS policy will eliminate all or most of their inappropriate one day stays and thereby protect themselves against the RAC audits. However, the Maryland hospitals that reduce their one day stays will not incur any payment reductions because, unlike the hospitals covered by the IPPS, the Maryland hospitals will not be required to forfeit the difference between their inpatient and outpatient payments for such cases. The protection afforded the Maryland hospitals by the ODS policy is unavailable to hospitals elsewhere in the U.S. It offers the greatest financial benefits and opportunities to those Maryland hospitals who are covered by the CPC system and had the most inappropriate one day stay cases in the Base Year.

The ODS policy also has another undesirable effect. Under the HSCRC system, ten (10) hospitals operate as Total Patient Revenue (TPR) hospitals. These hospitals are constrained by budget arrangements that strongly encourage them to eliminate all unnecessary volume, including inpatient admissions of any kind (including both one day stays and longer stays) and inappropriate outpatient services. For the TPR hospitals, neither the ODS policy nor the ARR is of any benefit whatsoever because the TPR hospitals operate under the constraint of their total patient revenue budgets. However, the negative Update Factor that the HSCRC staff has proposed for FY 2013, with the aim of protecting the Medicare waiver while maintaining the ODS policy, would be applied to each TPR hospital's target budget, with the effect of ratcheting these budgets down in FY 2013 (and probably in FY 2014) despite the fact that none of the ODS policy's financial benefits have flowed to these hospitals.

The TPR program is a cornerstone of the HSCRC's efforts to move to a PMPM-based form of cost containment. In addition, the TPR program is likely to be given a prominent place in the State's anticipated filing of a demonstration project with CMMI that would incorporate a new waiver test. It is reasonable to ask why the HSCRC would

punish the TPR hospitals for a problem they did not create. It is also reasonable to ask how many reductions to the budgets of the TPR hospitals it would take to make the TPR program financially unsustainable. The discriminatory impact of the proposed Update Factor and the related continuation of the ODS policy on the TPR hospitals is unfair and inconsistent with the HSCRC's expressed desire and intention to move to a population-based waiver test and hospital cost control system.

## I. The HSCRC Staff's Justification for Continuing the ODS Policy

The HSCRC staff's reason for maintaining the ODS policy involves technical concerns regarding the impact of reversing the policy and the inclusion of one day stays in the readmission program. In particular, the staff's recommendation on this matter in relation to the FY 2013 Update Factor includes the following observation:

> "While the Admission Readmission Revenue (ARR) agreements would allow the (1 day stay) cases to be reintegrated into the targets, this approach raises the possibility of unwarranted ARR rewards for further reductions in short stay cases."

We would agree with this concern if the elimination of the ODS policy would require the one day stay cases to be included in the ARR program. However, we do not agree that the elimination of the ODS policy, and the reestablishment of the previous CPC approach of calculating per case Allowable Charges for one day stay cases, must affect the ARR program. The one day stay cases could be kept outside the ARR program, as they are now, and their Allowable Charges could be based on APR DRG weights calculated in the same way in which they were calculated, prior to the implementation of the ODS policy, under the CPC arrangement.

The elimination of the ODS policy, the reestablishment of CPC rates for one day stay cases, and the continuation of the ARR program excluding one day stay cases (and using revised episode weights) could be accomplished through relatively simple and straightforward applications of the HSRV weighting system that is used in the prior CPC system. Therefore, there are no obvious or substantial technical barriers to eliminating the ODS policy without creating inappropriate charges in the ARR.

The effort the HSCRC staff would need to make to implement these technical changes would be amply justified by the elimination of an ODS policy that provides no demonstrable benefit to patients, saves no money, hurts the waiver margin, affords the greatest financial rewards to the hospitals that had the greatest percentage of inappropriate one day stays, and requires the imposition of an Update Factor that is unfair to hospitals that did not cause the one day stay problem including, most prominently, the TPR hospitals that are expected to be the bellwethers of a new, population-based Medicare waiver test and overall cost containment system.

* * * * * * * * *

SHORE HEALTH
UNIVERSITY OF MARYLAND
MEDICAL SYSTEM

219 South Washington Street
Easton, MD 21601
www.shorehealth.org

FROM THE OFFICE OF THE PRESIDENT

April 26, 2012

Mr. Patrick Redmon
Executive Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215-2299

Dear Mr. Redmon:

As president and CEO of Shore Health System, I am writing to share our position on the Fiscal Year 2013 Annual Payment Update for hospitals in Maryland. When considering the Hospital Update for Fiscal Year 2013, it is essential that Maryland's hospitals be provided with the resources that are needed not only to take care of people, but also to ensure access to important healthcare services. This is especially true for small rural community hospitals, like Shore Health, comprised of both Memorial Hospital at Easton and Dorchester General Hospital in Cambridge, that provide services over a five-county region.

Understanding our need to preserve the CMS waiver, Shore Health supports MHA's reluctant acceptance of the HSCRC Staff recommendations for a negative 1.0 percentage point update for inpatient services. However, it is important to note that our support is contingent on a full market basket increase (2.59 percent) for outpatient hospital services.

In combination with a negative update factor for inpatient regulated services, the lack of an increase in outpatient hospital rates will have a major adverse impact on Shore Health. As a TPR hospital, we are unable to offset less than inflationary rate increases by growing inpatient market share. We must rely on expense reductions beyond those already enacted from previous year's gaps with rate increases falling short of inflation. We are at the point now of considering reductions in our work force and elimination of services we offer to our community.

With the vision of creating a regional healthcare system that manages the health of an aging population within a five-county mid-shore region (Kent, Queen Anne's, Talbot, Caroline and Dorchester counties) under a TPR reimbursement model, it is essential that Shore Health partners with the HSCRC to achieve what I believe to be common

goals. Enacting the MHA's position on the market basket increase for outpatient hospital services will lessen the impact of a negative rate increase and not derail our vision for creating a healthier mid-shore region.

On behalf of Shore Health and the communities we serve, thank you in advance for your consideration when making this very important decision.

Sincerely,

Kenneth D. Kozel
President and CEO
Shore Health

Kdk/pkm

LIFEBRIDGE
HEALTH

2401 West Belvedere Avenue
Baltimore, MD 21215-5271
www.lifebridgehealth.org
410-601-5134
410-601-9487 fax

Warren A. Green
President and
Chief Executive Officer

April 25, 2012

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



Dear Mr. Redmond:

LifeBridge Health strongly endorses the decision to impose a one percent inpatient rate reduction on Maryland hospitals. Maintaining the waiver (while a parallel process to modernize it takes place) is of paramount importance, and painful though it may be, we subscribe to the tactic of lowering inpatient rates at this critical juncture.

However, we deem it essential that outpatient rates reflect the full market basket increase of 2.59 percent. Under this scenario, the blended rate of increase for Maryland hospitals will be approximately 0.3 percent—hardly robust, but something that we will adjust to for the coming rate year, even though we will be forced to make difficult decisions regarding the maintenance of jobs and the scope of essential programs.

An outpatient increase materially less than 2.59 percent will have dire consequences for our organization. It is virtually certain that significant cuts will have to be made in a broad array of vital services that we offer to the community. These curtailments would be unfortunate, for an inflationary increase to outpatient rates does not threaten the waiver.

We recognize that this is a difficult time for the Commission, providers of care, and the insurance industry. We further believe that by endorsing the inpatient rate reduction, we are demonstrating our commitment to do what is necessary and appropriate. In turn, we think it is imperative for the Commission to recognize the fragile state that Maryland hospitals are descending to, and to grant the 2.59 percent outpatient increase as a partial remedy to our deteriorating future financial outcomes.

Thank you for your careful consideration.

Sincerely,

Warren A. Green

CC: Mr. Mike Robbins
MHA Senior Vice President,
Financial Policy & Advocacy

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

**April 25, 2012**

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

**This is a Final Recommendation to be considered at the May 2, 2012 HSCRC public meeting.**

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

## Background

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

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

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

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

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

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

- FY 2012 - $1,314,433

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

**Maryland Patient Safety Center Request to Extend HSCRC Funding**

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

**Strategic Partnerships**

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

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

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

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

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

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

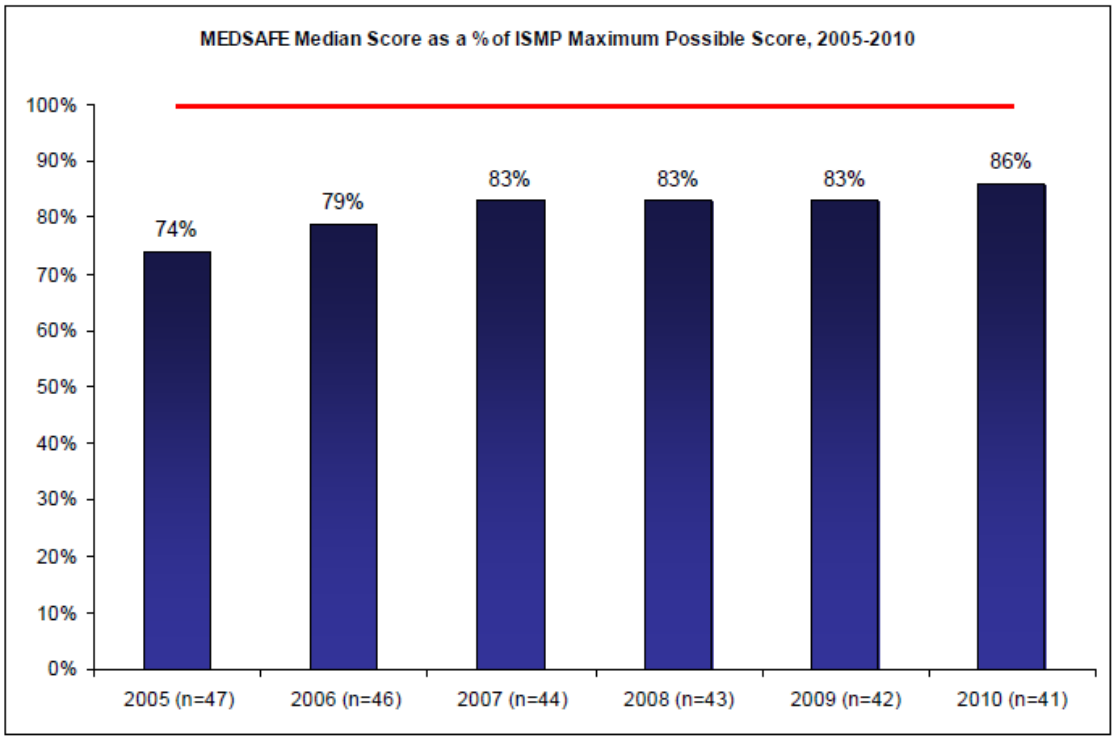
***MEDSAFE***

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

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

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

**Table 1. MEDSAFE Score Trends from 2005 to 2010**




***SAFE from FALLS***

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

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

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

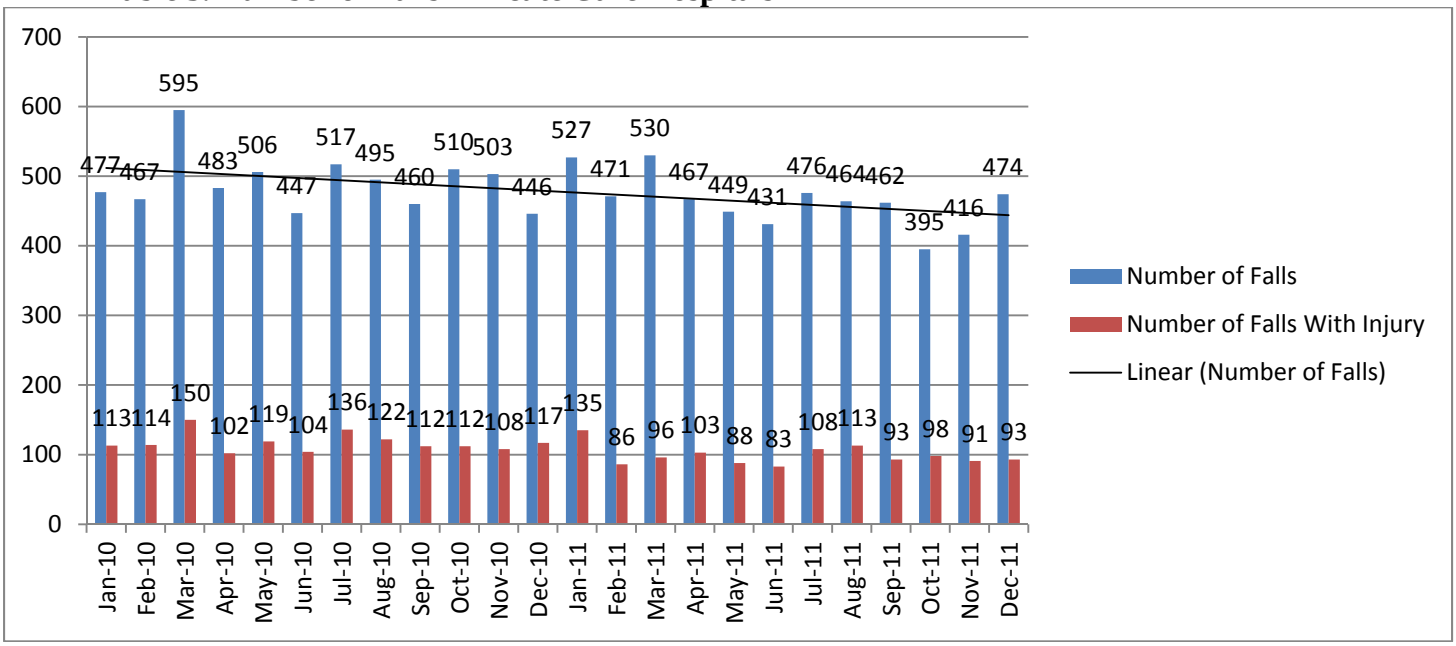
**Table 2. SAFE from FALLS Management Program and Care Bundle**

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

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

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

**Table 3. Number of Falls in Acute Care Hospitals**




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

***Perinatal and Neonatal Learning Collaborative***

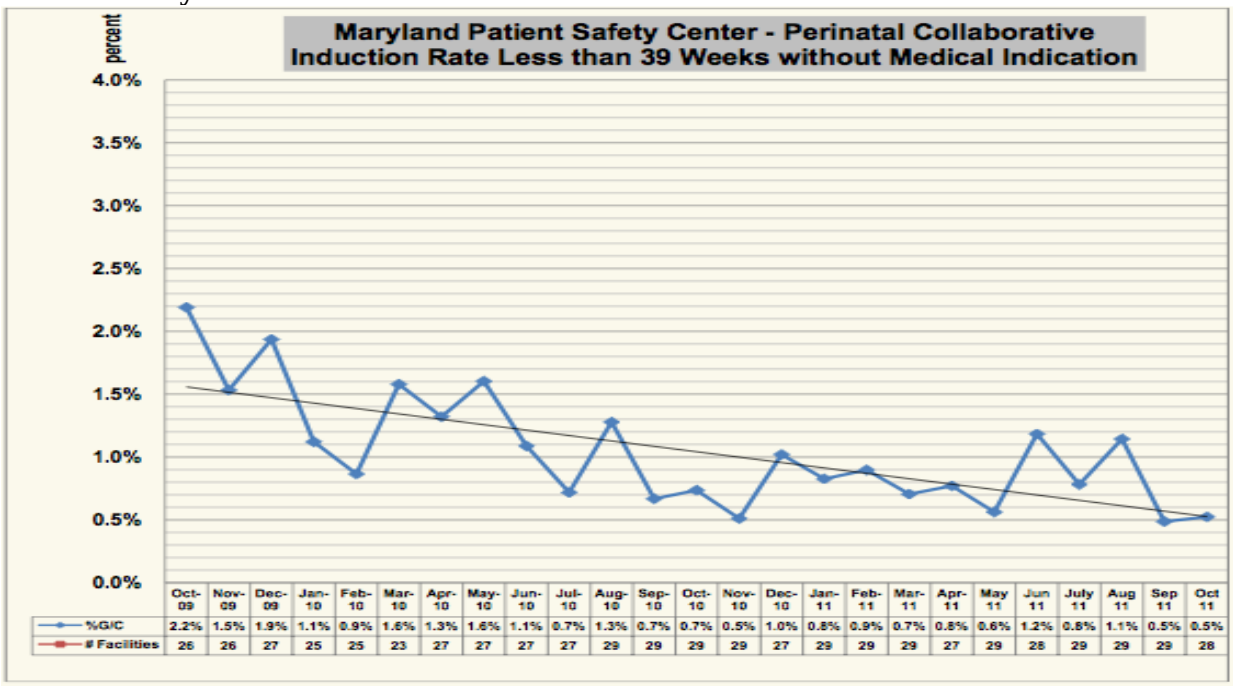
The purpose of the perinatal and Neonatal Learning Collaborative is to reduce elective inductions and c-sections prior to 39 weeks without medical indication, improve neonatal outcomes, and standardize the discharge process for mothers and infants including the late pre-term infant. Table 4 below outlines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

**Table 4. Perinatal and Neonatal Learning Collaborative Timeline**

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

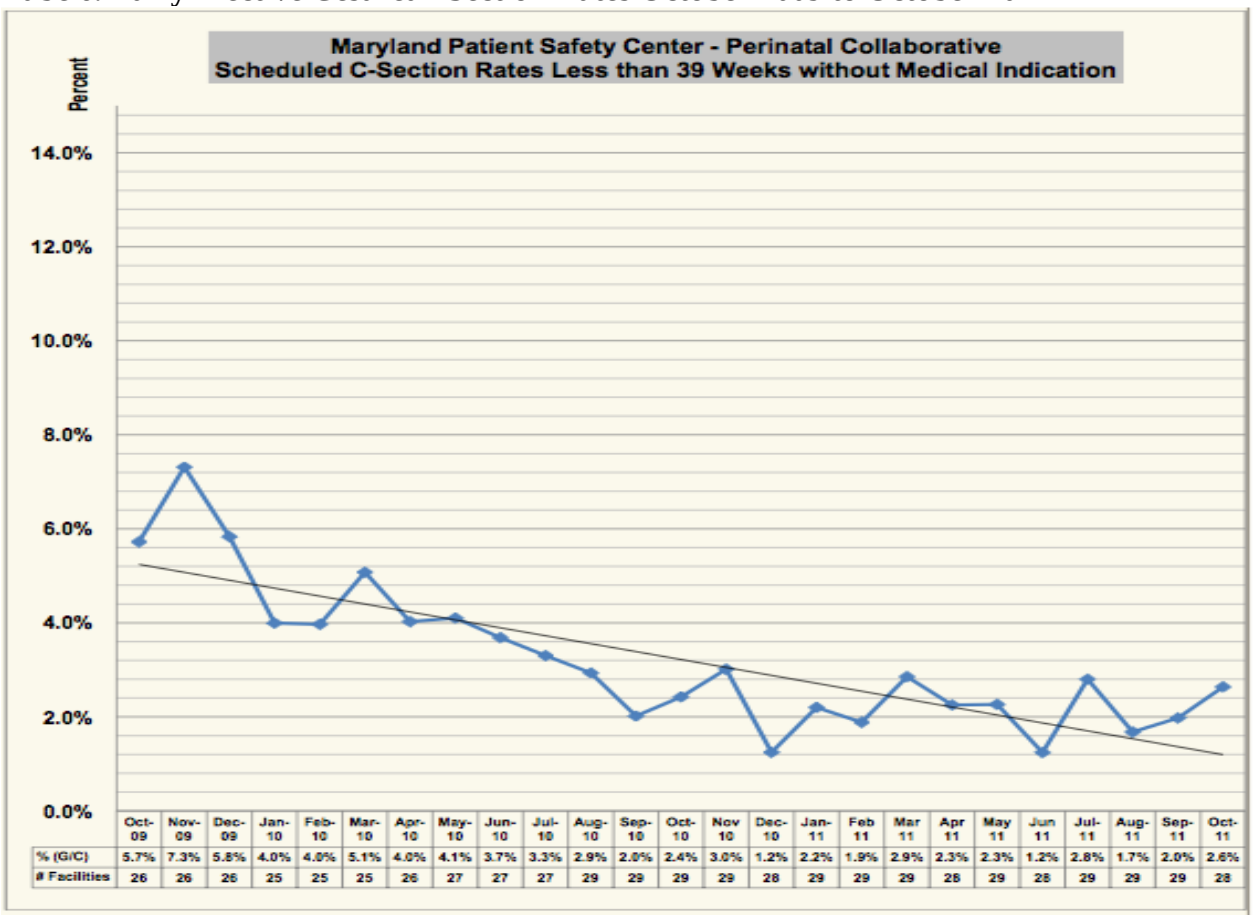
Tables 5 and 6 below illustrate the decrease in rates of early, elective deliveries as measured by collaborative hospital participants. These measures are targeted at decreasing neonatal mortality, and morbidity.

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




| | Oct-09 | Nov-09 | Dec-09 | Jan-10 | Feb-10 | Mar-10 | Apr-10 | May-10 | Jun-10 | Jul-10 | Aug-10 | Sep-10 | Oct-10 | Nov-10 | Dec-10 | Jan-11 | Feb-11 | Mar-11 | Apr-11 | May-11 | Jun-11 | July-11 | Aug-11 | Sep-11 | Oct-11 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| %G/C | 2.2% | 1.5% | 1.9% | 1.1% | 0.9% | 1.6% | 1.3% | 1.6% | 1.1% | 0.7% | 1.3% | 0.7% | 0.7% | 0.5% | 1.0% | 0.8% | 0.9% | 0.7% | 0.8% | 0.6% | 1.2% | 0.8% | 1.1% | 0.5% | 0.5% |
| # Facilities | 26 | 26 | 27 | 25 | 25 | 23 | 27 | 27 | 27 | 27 | 29 | 29 | 29 | 29 | 27 | 29 | 29 | 29 | 27 | 29 | 28 | 29 | 29 | 29 | 28 |

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




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

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

**Table 7. Neonatal Measures October 2009 to November 2011**

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

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

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

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

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

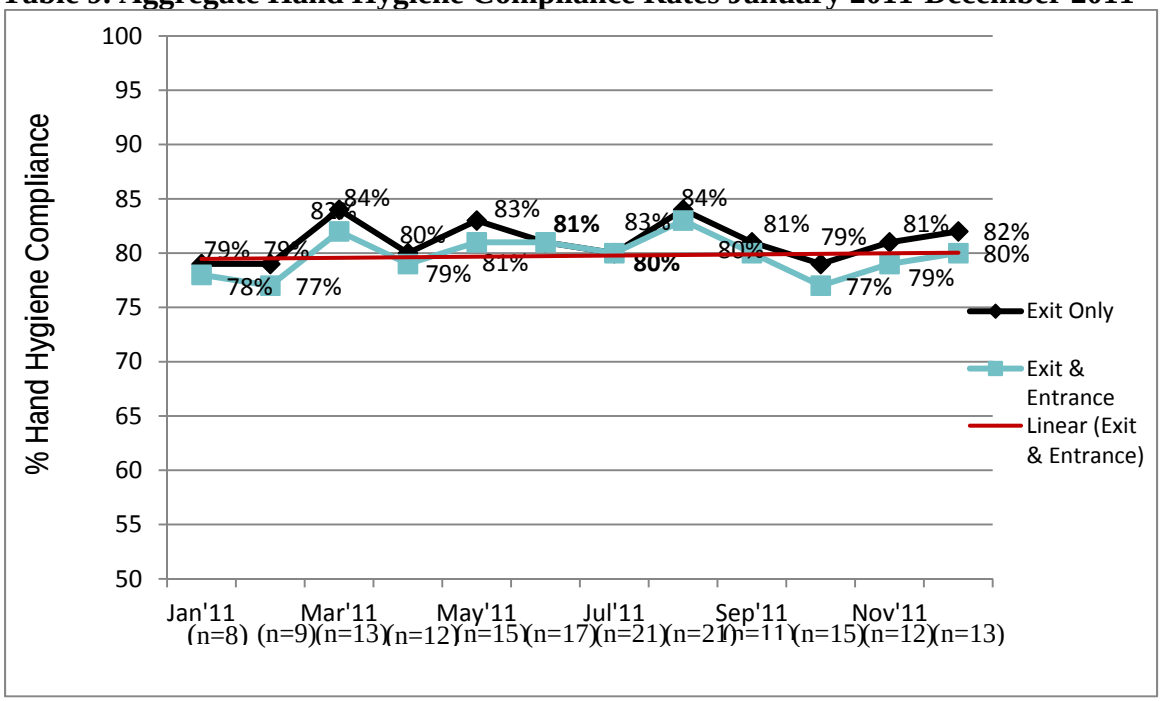
| | 2011 Combined Collaborative AHRQ Survey Average | AHRQ 2012 User Comparative Database Report – OB Unit | 2009 Perinatal Collaborative AHRQ Survey Average | 2009 Neonatal Collaborative AHRQ Survey Average |
|---|---|---|---|---|
| Communication Openness | 79% | 61% | 60% | 62% |
| Feedback and Communication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

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

***Hand Hygiene Collaborative***

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

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




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

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

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

***Adverse Event Reporting***

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

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

***Spreading Excellence through Educational Programming***

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

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

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

**Table 10. Participants and Hospitals Accessing MPSC Educational Programs**

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

**Other Sources of Funding**

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

Table 11. Other MPSC Funding FY 12and FY 13

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

**Findings**

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

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

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

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

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

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

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

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

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

**Staff Recommendations:**

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

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

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

3. **Undertake an analysis of the level of participation of hospitals and other provider settings in MPSC projects as well as the standardization of self reported data collection. Report the findings and any next steps to improve participation and data collection standardization to the Commission no later than October 31, 2012.**

4. **To encourage and support greater numbers of providers in settings other than hospitals to work with the MPSC, hold in abeyance $100,000 of the requested funding until the MPSC develops and submits to the Commission a feasibility study and options for relocating the Center in a physical location other than the Maryland Hospital Association. The study and proposed options should be submitted the Commission no later than December 31, 2012.**

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

6. **The MPSC should continue to aggressively pursue other sources of revenue, including from other provider groups that benefit from the programs of the Center, to help support the Center into the future.**

# Appendix I

# Maryland Patient Safety 2012 Report and Proposal for 2013 Funding

# Maryland Patient Safety Center FY 2013 Program Plan & Budget

**Presented to the Health Services Cost Review Commission**

**April 11, 2013**

# Creation of the Maryland Patient Safety Center

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

# MPSC Awards & Distinctions

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

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- **Kathleen White**, PhD, RN, NEA-BC, FAAN, Senior Advisor, National Center for Health Workforce Analysis, Senior Advisor, Advanced Nursing Education, Division of Nursing, Bureau of Health Professions, Health Resources & Services Administration

# Strategic Priorities

MARYLAND Patient Safety CENTER

Vision - *Who we are*

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

Mission – *Why we exist*

Making health care in Maryland the safest in the nation

Goals - *What will we accomplish*

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

Strategic Areas of Focus - *What we will do*

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

# Strategic Dashboard

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

# Strategic Partners

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

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

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

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

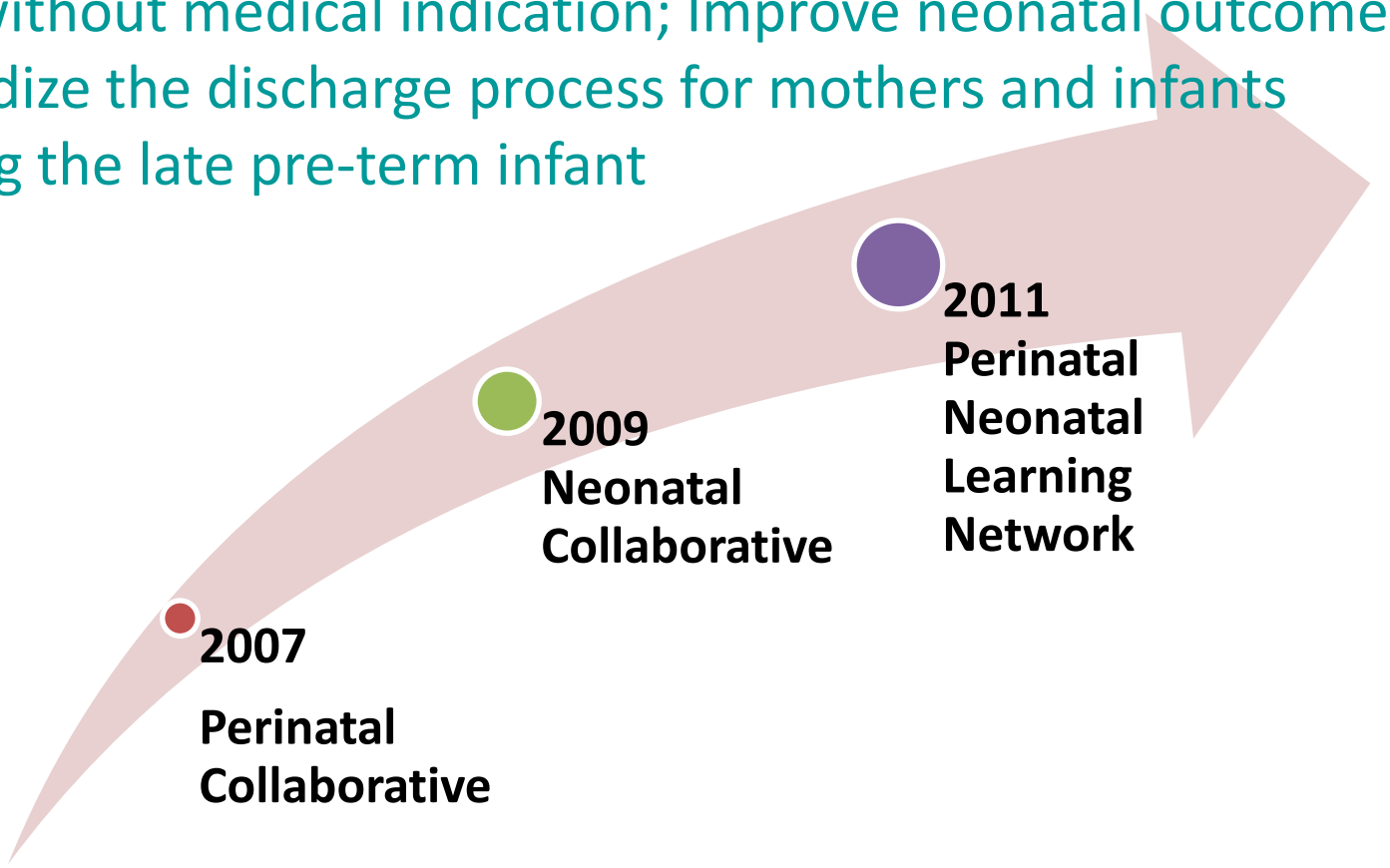
- **The Armstrong Institute for Patient Safety and Quality** – The new patient safety center within Johns Hopkins Medicine. The Armstrong Institute is a subcontractor to the Maryland Patient Safety Center leading the reduction of central line-associated blood stream infections in outpatient dialysis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

# Collaboratives: Purpose and Results

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

# Perinatal/Neonatal Collaborative

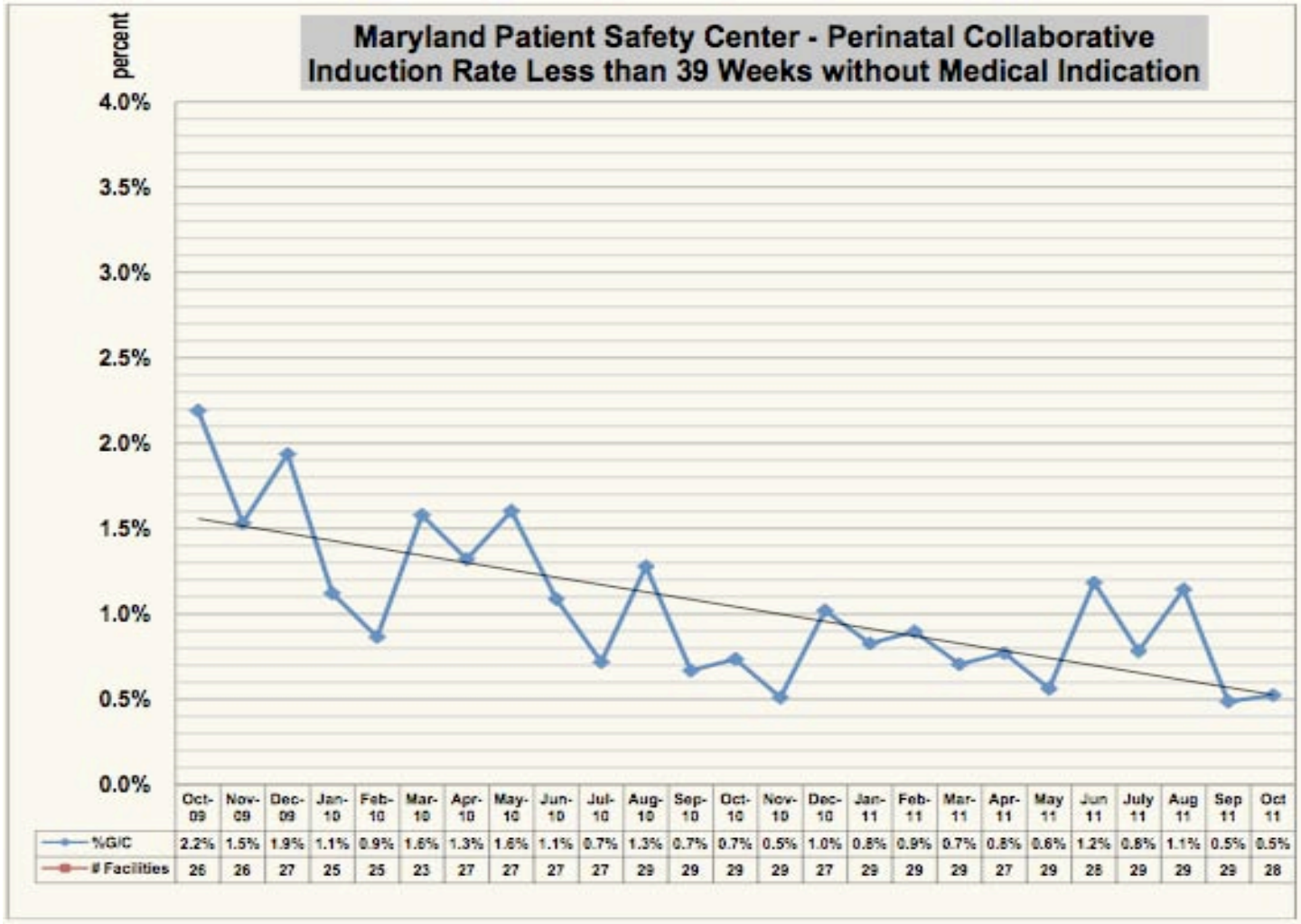
Purpose: Reduce elective inductions and c-sections prior to 39 weeks without medical indication; Improve neonatal outcomes; Standardize the discharge process for mothers and infants including the late pre-term infant



# Details: Perinatal/Neonatal Collaborative

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

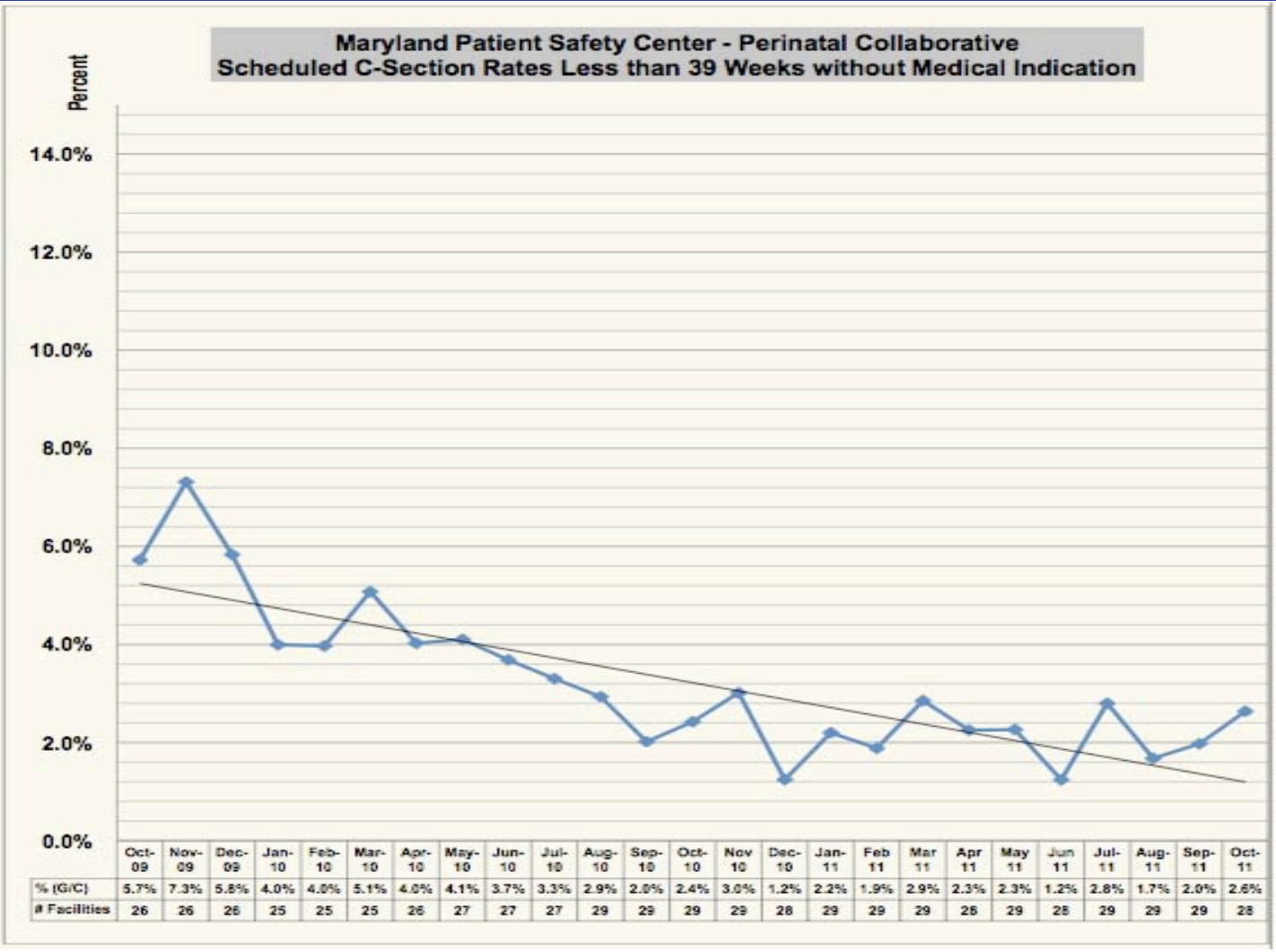
# Results:
# Inductions <39 Weeks w/o Medical Indication



# Results: Inductions <39 Weeks w/o Medical Indication

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

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




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

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

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

# Results: "Golden Hour" Measures

MARYLAND Patient Safety CENTER

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

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

# Results:
# AHRQ Culture of Safety Survey

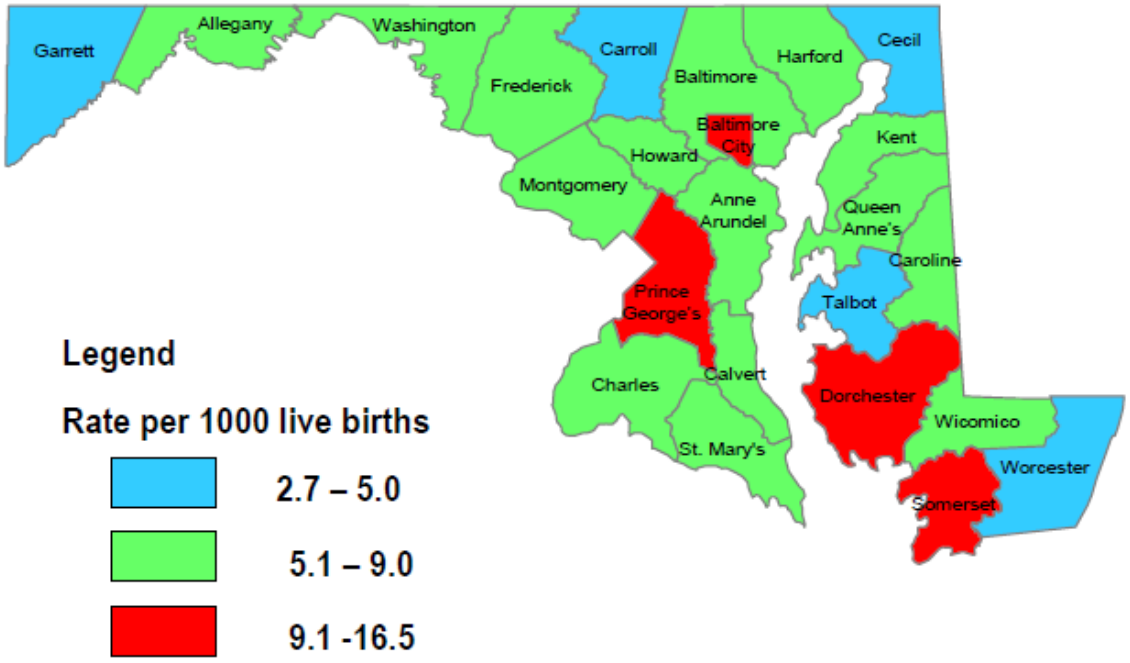
**(Survey of process improvement by Perinatal/Neonatal Collaborative participants)**

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

# Area of Focus – FY13

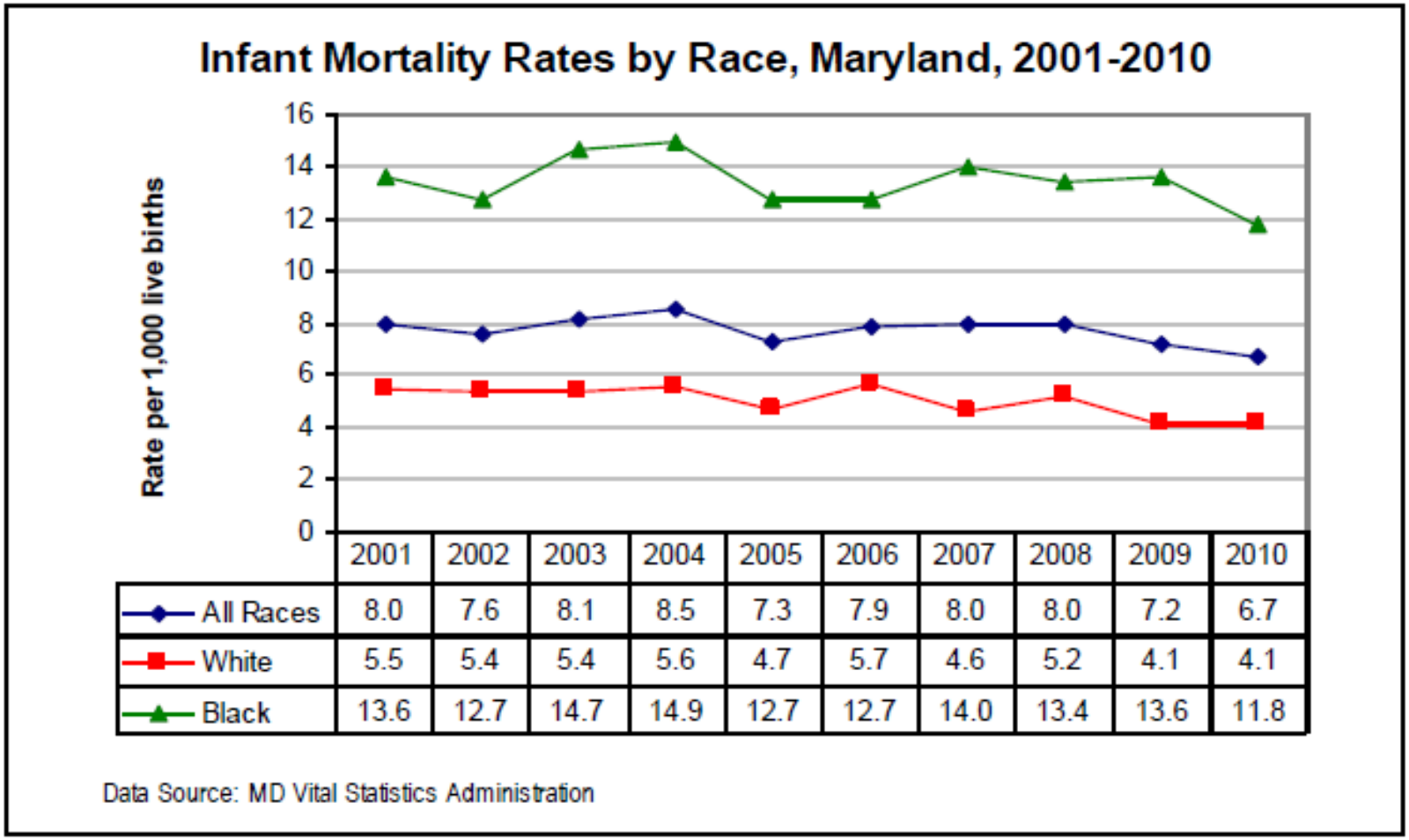
## Geographic Disparity in Maryland

### Average Infant Mortality Rate, By Jurisdiction, 2005-09




Data Source: MD Vital Statistics Administration

# Racial Disparity in Infant Mortality




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

Data Source: MD Vital Statistics Administration

# Next Steps: Perinatal/Neonatal Collaborative

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

# SAFE from FALLS Collaborative

Maryland Patient Safety Center

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

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

# Details:
# SAFE from FALLS Collaborative

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

**Fall Management Program**

**S** – Safety coordination

**A** – Accurate and concurrent reporting

**F** – Facility expectations, staff education

**E** – Education for patients and families

**Patient/Resident Care Bundle**

**F** – Falls risk screening

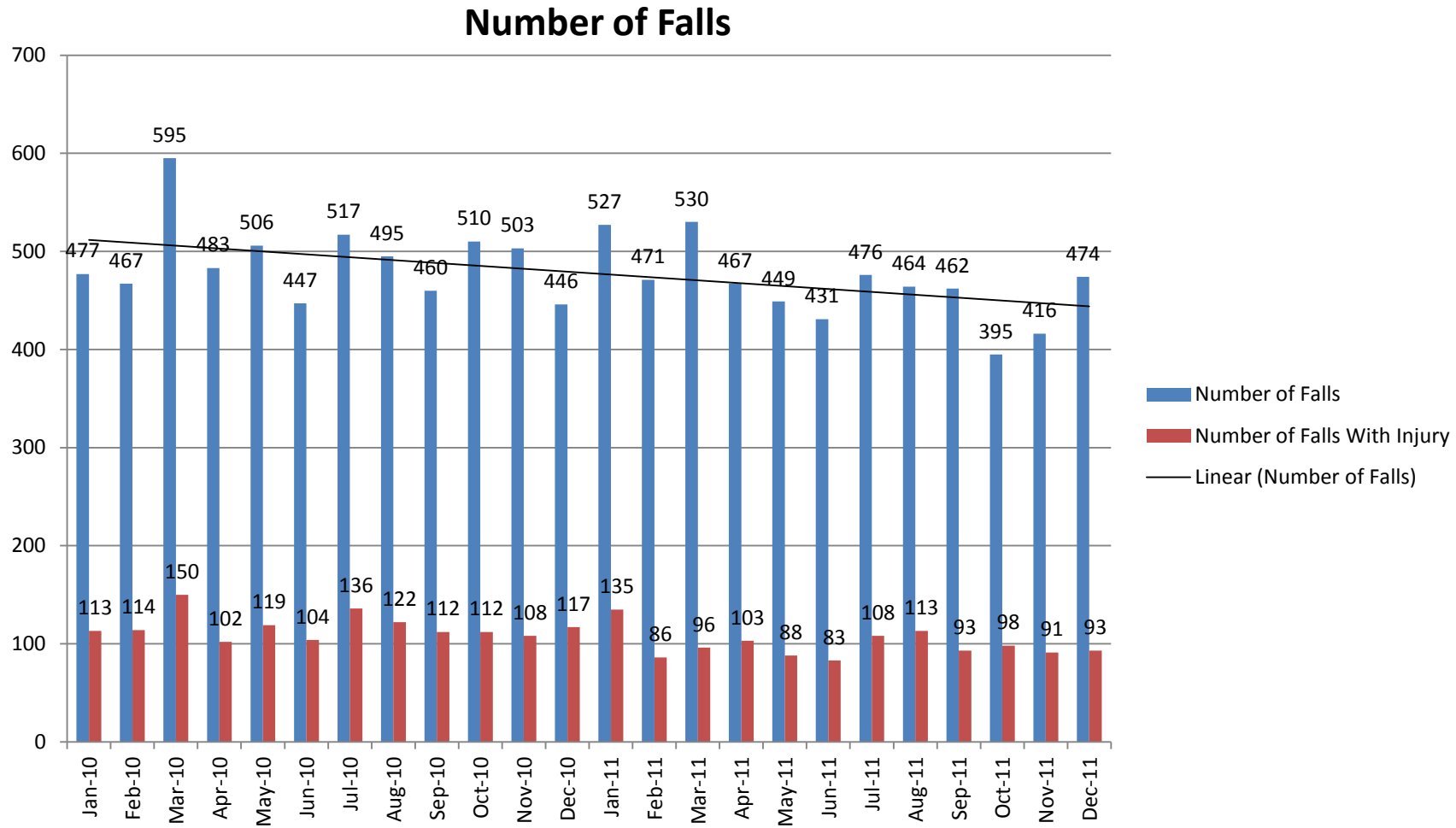
**A** – Assessment of risk factors

**L** – Linked interventions

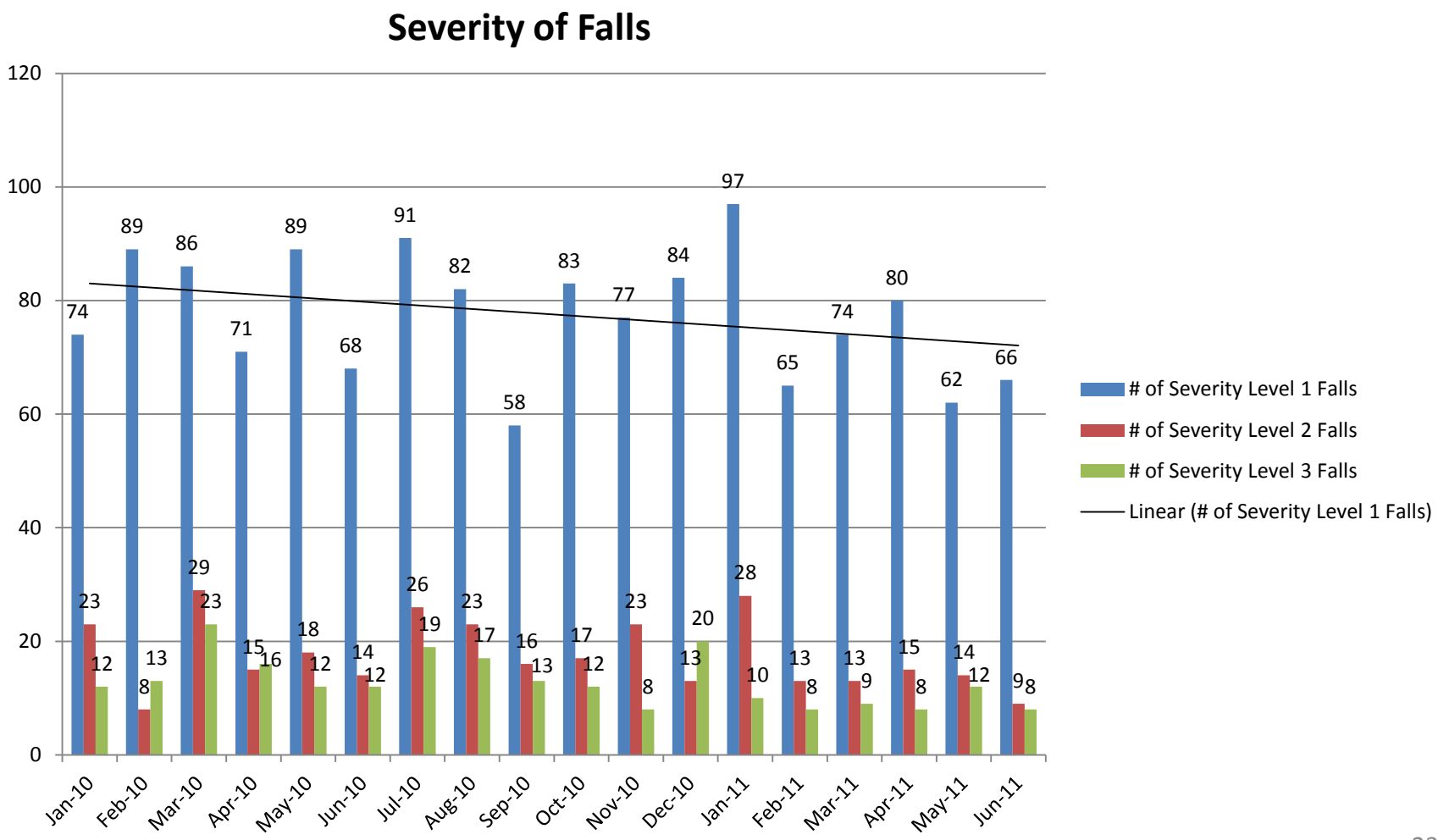
**L** – Learn from events

**S** – Safe environment

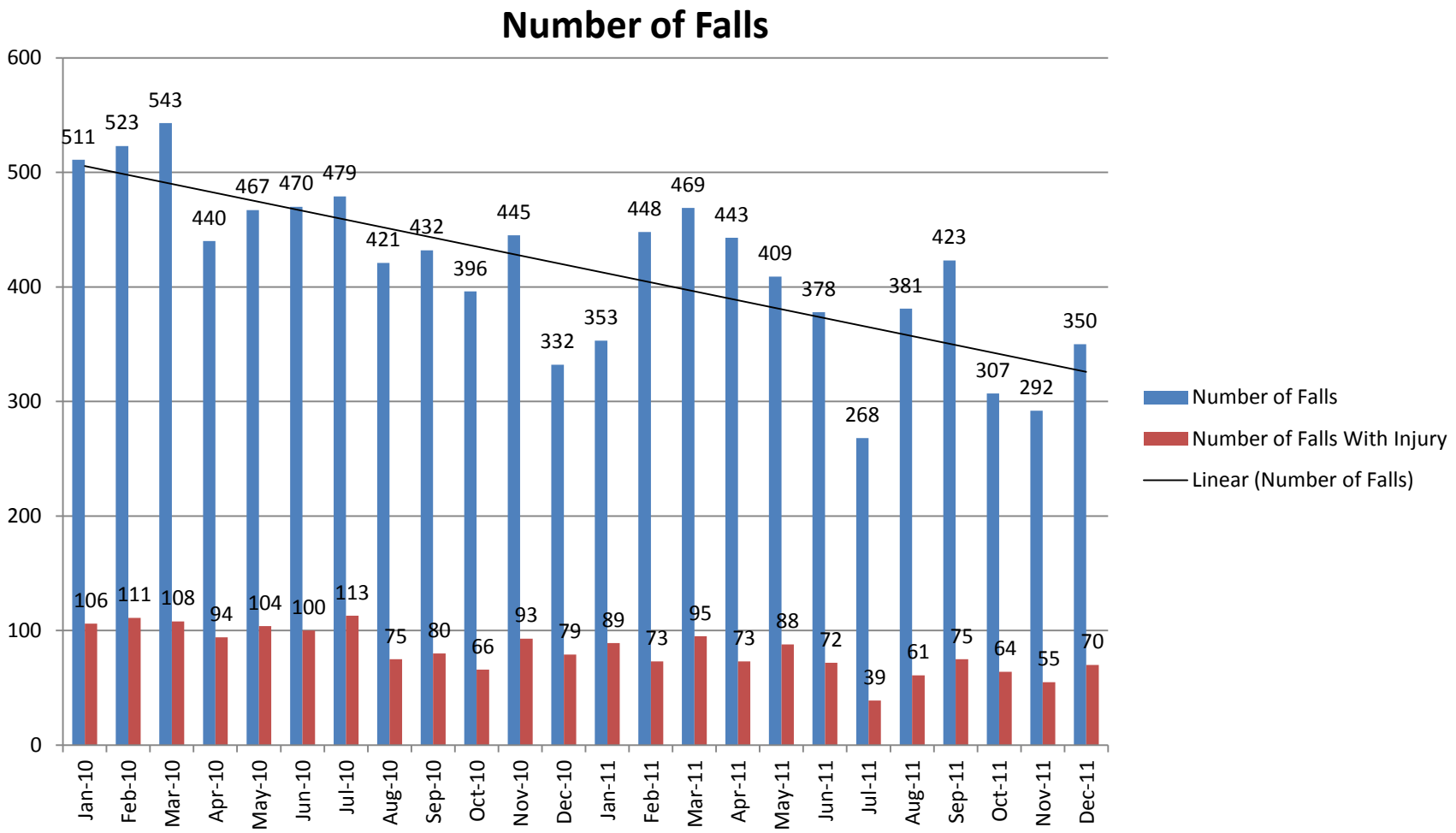
# Results:
# SAFE from FALLS Acute Care



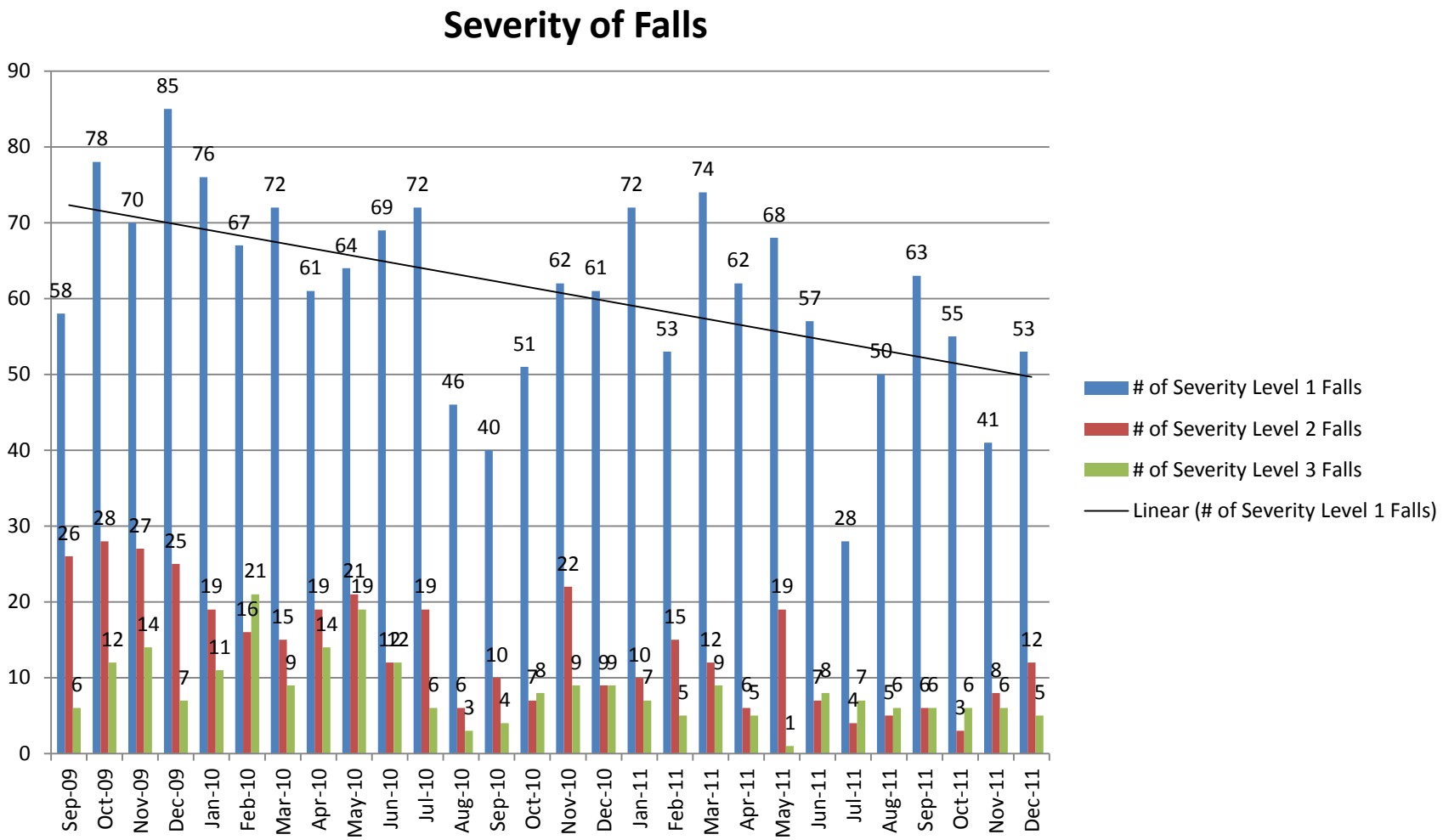
# Results:
# SAFE from FALLS Acute Care



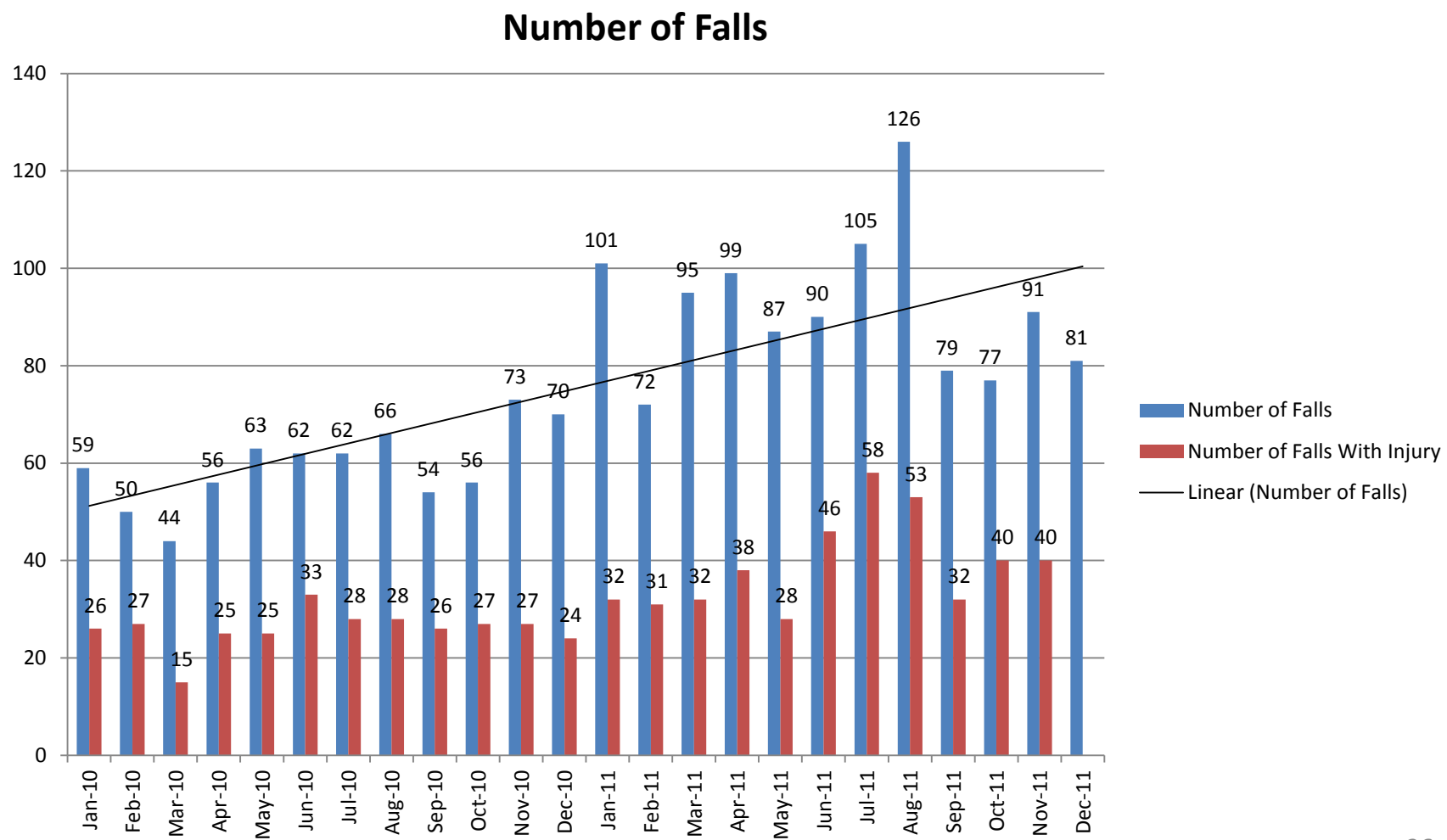
# Results:
# SAFE from FALLS Long Term Care



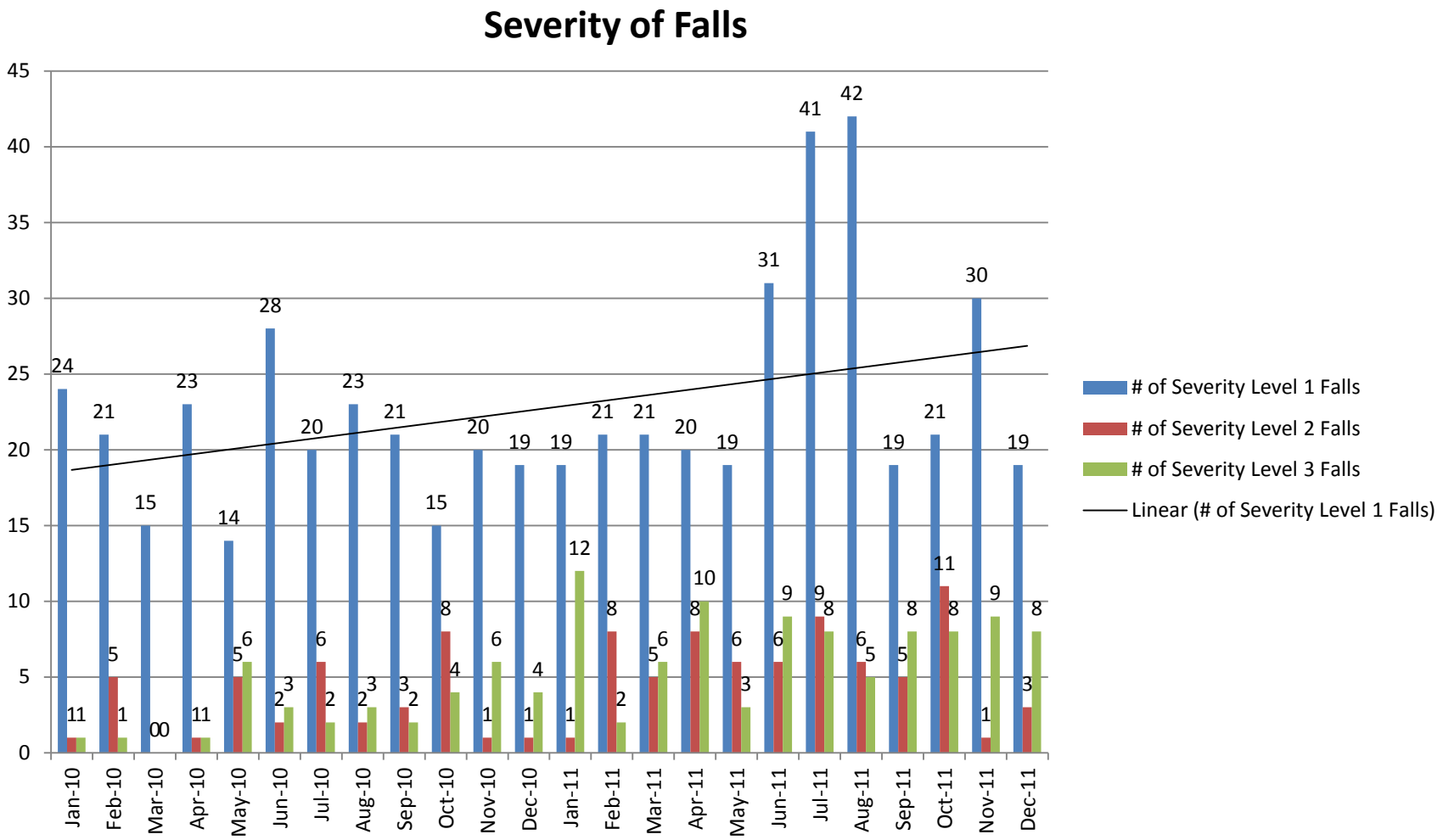
# Results:
# SAFE from FALLS Long Term Care



# Results:
# SAFE from FALLS Home Health



# Results:
# SAFE from FALLS Home Health



# Results:
# SAFE from FALLS – Numbers of Falls

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

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

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

# Results:
# SAFE from FALLS – Severity of Falls

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

| Year | Ratio: No Harm to Harm |
|---|---|
| 2010 | 2.98<br>(2.98 falls with no harm for every fall with harm) |
| 2011 | 3.64<br>(3.64 falls with no harm for every fall with harm) |

# Next Steps: SAFE from FALLS

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

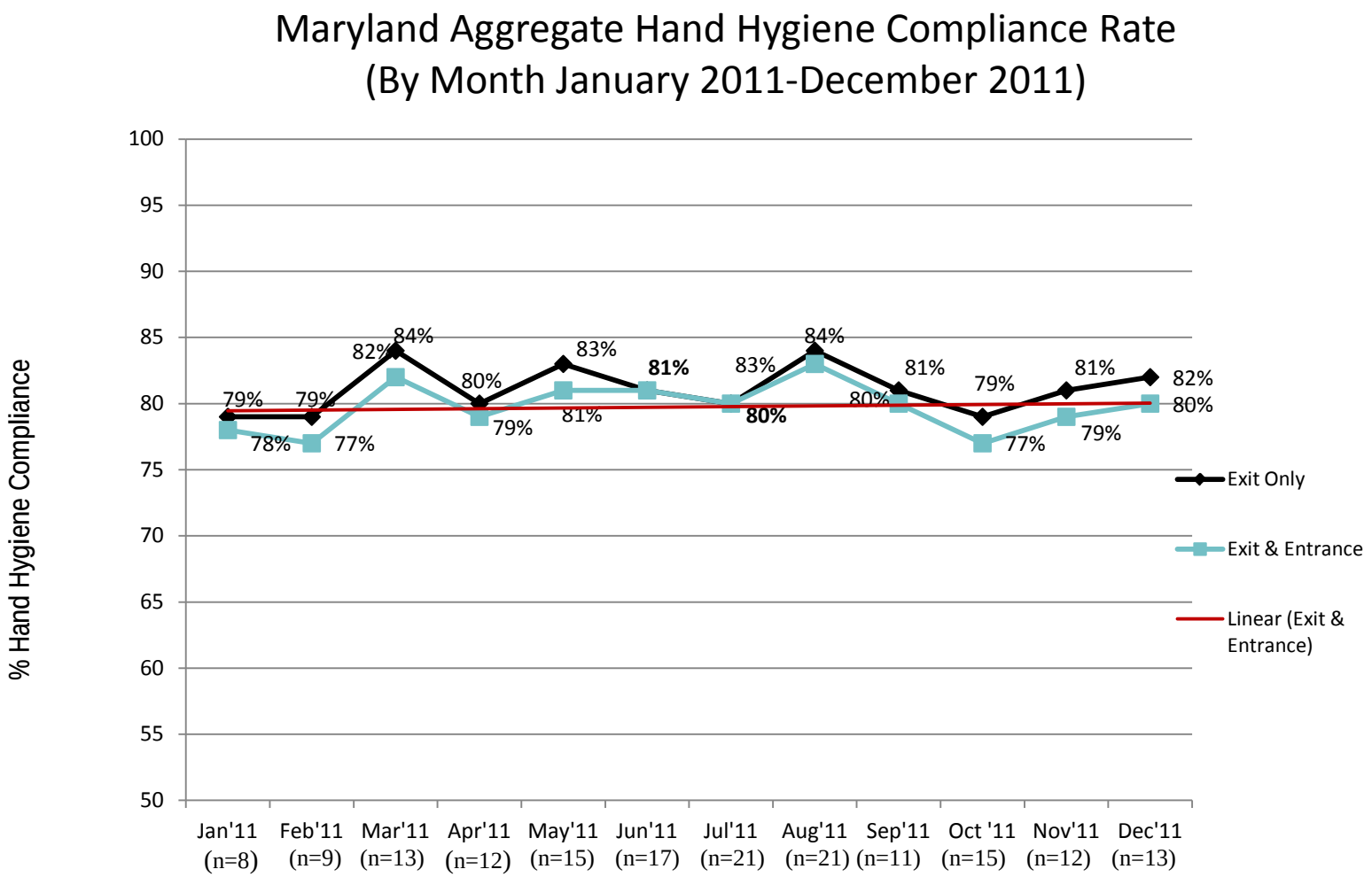
# Hand Hygiene Collaborative

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

# Details:
# Hand Hygiene Collaborative

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

# Early Results: Hand Hygiene Collaborative




N = number of hospitals meeting the 80/30 rule

# Next Steps: Maryland Hand Hygiene Collaborative

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

# Adverse Event Reporting

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

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

# MEDSAFE

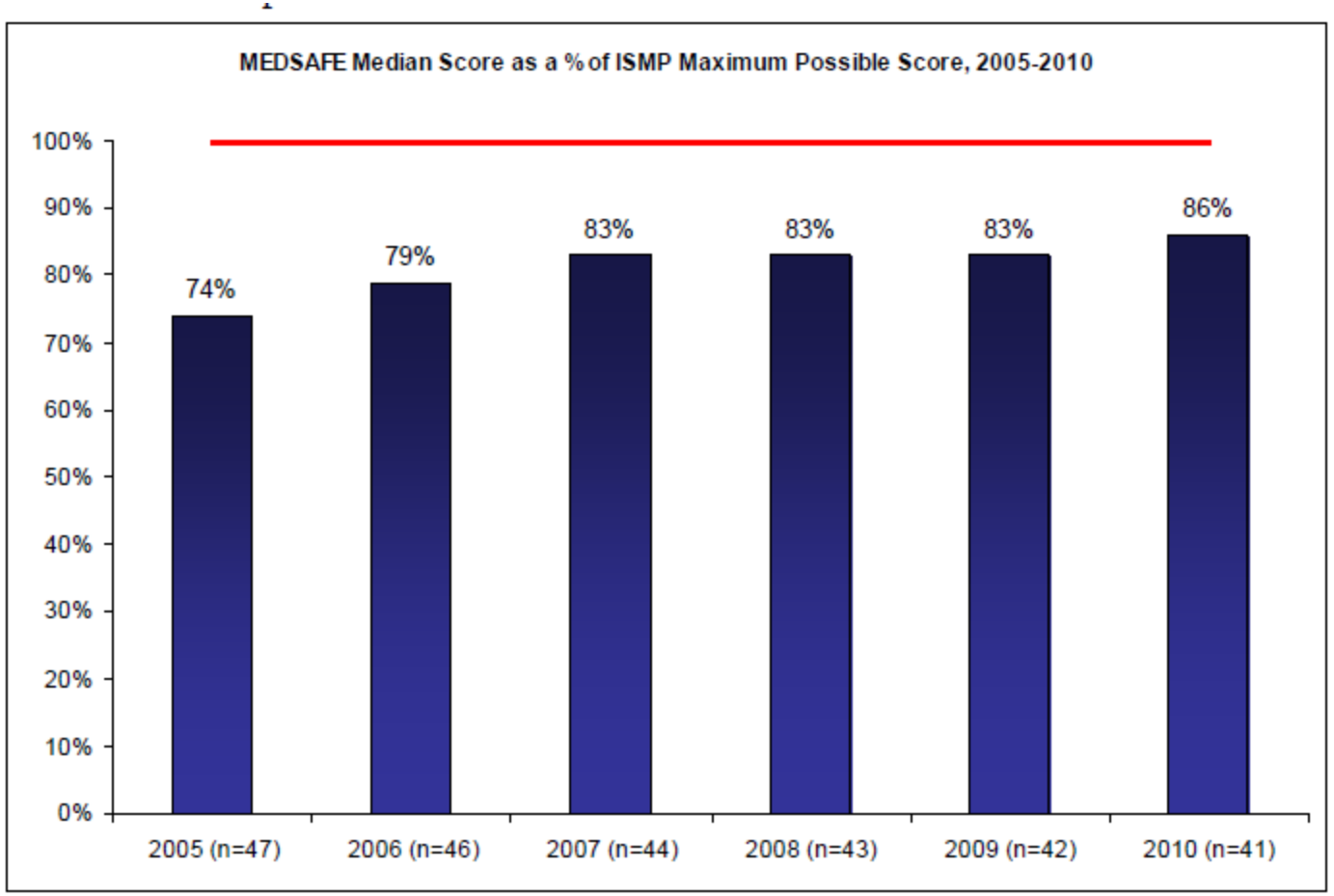
Purpose: to systematically assess the processes that hospitals have in place to ensure the safe use of medications

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

# Details: MEDSAFE

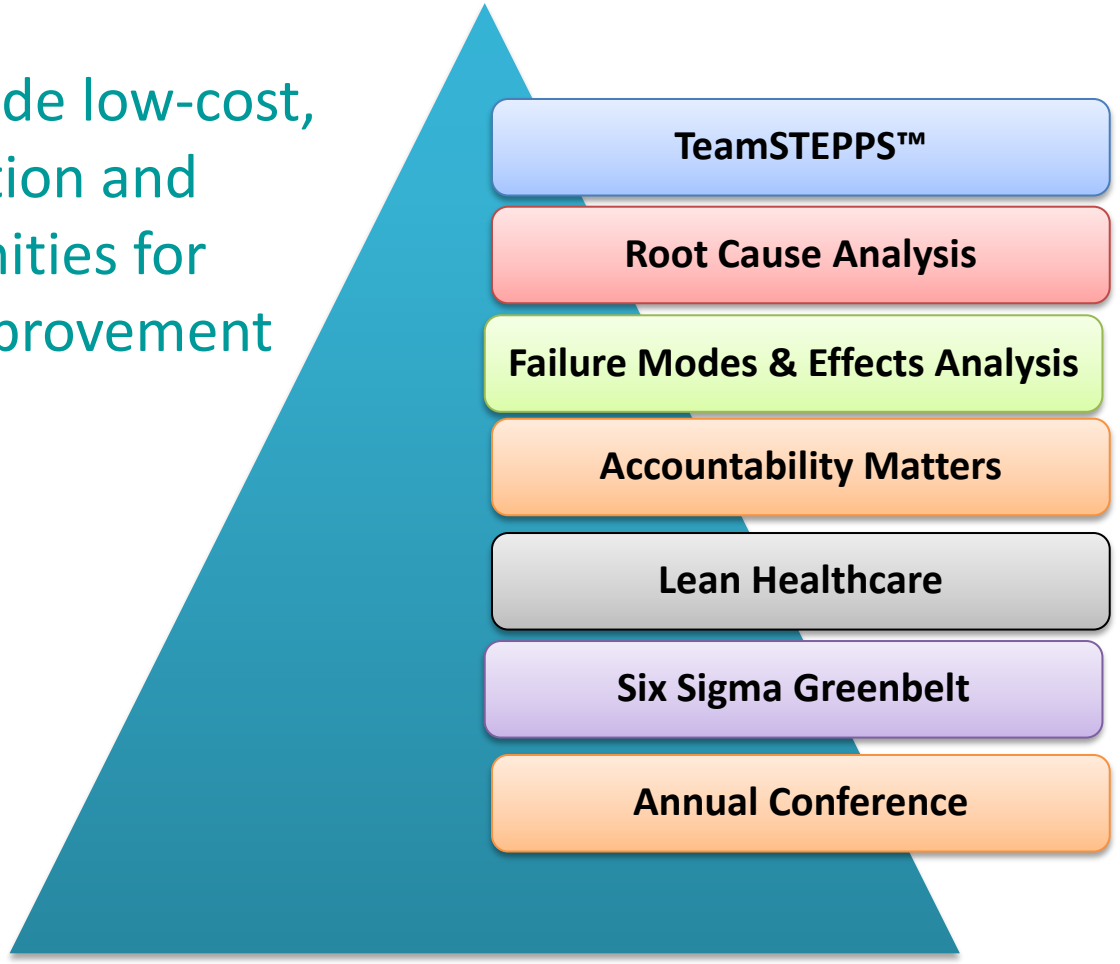
- MEDSAFE was launched in 2000
- MEDSAFE participants use the Institute for Safe Medication Practices (ISMP) Safety Self-Assessment® to assess the safety of medication practices within their organization
- In 2012, 42 of 46 hospitals in Maryland completed the ISMP self-assessment survey
- On an annual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

# Results: MEDSAFE



# Education Offerings

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



# Results: Education & Training

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

* Programs scheduled but not yet held in FY12

# FY 2013 Budget

MARYLAND Patient Safety CENTER

**REVENUE**

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

**EXPENSES**

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

# FY 2013 Budget Key Assumptions

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

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

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

# Draft Recommendation on Changes to the Uncompensated Care Regression Model Outpatient Variables

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

May 2, 2012

This recommendation is a draft proposal. No Commission action is required at this time. Public comments should be sent to Nduka Udom at the above address or by e-mail at ndukau@hscrc.state.md.us. For full consideration, comments must be received by May 28, 2012.

## Introduction

The purpose of this paper is to recommend for Commission approval changes to the outpatient variables used in the uncompensated care regression model when setting prospective rates. This recommendation is a draft proposal, and no Commission action is required at this time.

The HSCRC's provision for uncompensated care in hospital rates is one of the hallmarks of rate regulation in Maryland. Uncompensated care includes bad debt and charity care. By recognizing reasonable levels of bad debt and charity care in hospital rates, the system enhances access to hospital care for those citizens who cannot pay for care. The uncompensated care provision in rates is applied prospectively and is meant to be predictive of actual uncompensated care costs in a given year. As a component of the uncompensated care methodology, the HSCRC uses a regression methodology as a vehicle to predict actual uncompensated care costs in a given year.

The uncompensated care methodology has undergone substantial changes over the years since it was initially established, including changes to the variables used in the predictive regression and the funding through pooling. The most recent version of the uncompensated care policy was adopted by the Commission on July 6, 2011 to accommodate a new approach to the Charity Care Adjustment.

With the HSCRC's collection of more robust outpatient data over the last three years, this draft recommendation proposes to change two of the variables used in the uncompensated care predictive regression as discussed below.

This recommendation does not modify the overall uncompensated care model, other methodologies associated with the calculation of uncompensated care, the allocation of uncompensated care in rates, the charity care adjustment, nor does this recommendation alter the policies regarding uncompensated care pooling.

## The Uncompensated Care Model

Under the current policy, HSCRC staff compute the amount of uncompensated care in rates as follows:

1. Compute a three-year moving average for uncompensated care for each hospital
2. Use the most recent three years of data to compute the uncompensated care regression (while adding "dummy" variables for each year)
3. Generate a predicted value for the hospital's uncompensated care rate based on the last available year of data
4. Compute a 50/50 blend of the predicted and three-year moving average as the hospital's amount in rates
5. Calculate the statewide amount of uncompensated care in rates from this process, and generate the percentage difference between the preliminary amount in rates and the last year of actual experience
6. Multiply the percentage difference (step 5) by the hospital's preliminary uncompensated care rate (step 4) to get adjusted rates that tie to the State's last year of actual UCC experience (this is referred to as the Revenue Neutrality Adjustment)

7. Take the results (step 6) by hospital and make the charity care adjustments to them (Charity Care Adjustment is calculated as 20% of the deviation of Expected Rate from Actual Charity Care).

HSCRC staff use the result is the hospital's uncompensated care rate for the next fiscal year in the calculation of the 100 percent statewide uncompensated care pool.

## Current Variables Used in the Uncompensated Care Regression

Within the uncompensated care model, the uncompensated care regression--Step 2 in the model described above--estimates the relationship between a set of explanatory variables and the rate of uncompensated care observed at each hospital as a percentage of gross patient revenue. Under the current policy, HSCRC staff includes the following as explanatory variables:

- Inpatient
    - Variable 1: The proportion of a hospital's total charges from inpatient non-Medicare admissions through the emergency department
    - Variable 2: The proportion of a hospital's total charges from inpatient Medicaid, self-pay, and charity cases
- Outpatient
    - Variable 3: The proportion of a hospital's total charges from outpatient Medicaid, self-pay, and charity visits to the emergency department
    - Variable 4: The proportion of a hospital's total charges from outpatient charges

## Discussions Surrounding the Outpatient Variables used in the Regression Model

When the Commission adopted the variables used in the regression model at its May 2, 2007 public meeting, the Johns Hopkins Health System and Mercy Medical Center commented to Commission staff that the outpatient variable, "the proportion of a hospital's total charges from outpatient services" (Variable 4, above), did not adequately capture the true measure of the outpatient poor population at many Maryland hospitals. The commentators contended that while the variable was statistically significant in helping to explain the overall uncompensated care level across all hospitals, it also inadvertently penalized hospitals with invariably high outpatient emergency room visits, but whose proportion of hospital's total charges from outpatient services appeared to be relatively small. The commentators attributed this to the fact that the Commission did not collect comprehensive outpatient data from hospitals. At that time, the only outpatient datasets collected by the Commission were ambulatory care and ambulatory surgery data.

The Commission began the collection of comprehensive outpatient data from Maryland hospitals under its jurisdiction effective July 1, 2007, including emergency department visit data. From the inception of this enhanced data collection effort, Commission staff intended to reevaluate Variable 4 ("the proportion of a hospital's total charges from outpatient services") as an outpatient measure in the regression model. Commission staff understands that outpatient uncompensated care is due partly to high uncollectable copayments and coinsurance associated with certain outpatient services such as the emergency department and clinic visits.

With FY 2011 outpatient data, Commission staff now has available the three consecutive and complete years of outpatient data needed to reevaluate the outpatient variables used in the regression model to predict the reasonable levels of bad debt and charity care in hospital rates.

Over the past few months the Financial Technical Issues Task Force of the Maryland Hospital Association (MHA) and Commission staff has been working independently on a range of possible measures to replace the current outpatient variables in the regression model. On February 14, 2012, the MHA representatives met with Commission staff to discuss the findings.

Based on that meeting and subsequent review of the regression predictive variables, MHA representatives and Commission staff agree to recommend that the Commission replace both outpatient regression variables (Variables 3 and 4). We suggest that in the regression model the Commission:

- Variable 3:
    - Remove: The proportion of a hospital's total charges from outpatient Medicaid, self-pay, and charity visits to the emergency department
    - Replace with: The proportion of a hospital's total charges from outpatient non-Medicare emergency department charges
- Variable 4:
    - Remove: The proportion of a hospital's total charges from outpatient services
    - Replace with: The proportion of a hospital's total charges from outpatient Medicaid, self-pay, and charity visits

## Impact of the Changed Uncompensated Care Regression Model Outpatient Variables

Commission staff considers the change to the outpatient variables to be an improvement to the current methodology, conceptually, statistically, and analytically. The change incorporates newly available data to better predict actual uncompensated care in the system. Updating the outpatient variables is especially important now with the recent shifts of hospital services from the inpatient to the outpatient setting.

These recommended changes to the outpatient regression variables do not alter the total prospective uncompensated care dollars built into rates across the system. Instead, these variable changes result in an improved distribution of that revenue among hospitals in the rate setting system.

Exhibit 1 shows the results of a preliminary calculation of uncompensated care rates for FY 2013 with the regression model Variables 3 and 4 replaced. Exhibit 2 provides a summary of the preliminary results from the model with the charity care adjustment. Exhibit 3 provides a statistical summary of the data elements and regression results of the current and the proposed methodologies. Exhibit 4 shows the difference in uncompensated care rates by comparing the results of the current and the proposed methodologies by hospital. Note in Exhibit 4 that the overall statewide difference is 0%.

Commission staff will publish the final results of this change in the regression variables for calculating uncompensated care when all the data for this report have been checked and validated by hospitals by the end of June 2012.

Note that as Commission staff continue to refine methodologies based on newly available data, the Commission should emphasize again to hospital staff the continued need for hospitals to ensure outpatient data quality.

## Recommendation

HSCRC staff recommends that the variables "the proportion of a hospital's total charges from outpatient Medicaid, self-pay, and charity visits to the emergency department" and "the proportion of a hospital's total charges from outpatient non-Medicare emergency department charges " be replaced by "the proportion of a hospital's total charges from outpatient services" and "the proportion of a hospital's total charges from outpatient Medicaid, self-pay, and charity visits," respectively, as outpatient measures in the regression model used to establish the uncompensated care provision for Maryland acute care hospitals, effective July 1, 2012.

## Exhibit 1
## Policy Results from the Regression and Revenue Neutrality Adjustment for FY 2013

| Hospid | Hospital Name | UCC in Rates (July 1, 2011) | Actual UCC for FY 11 | Adjusted UCC for FY 11 (Includes Averted Bad Debt) | Predicted UCC | FY 09- FY 11 UCC Average | 50/ 50 Blended UCC Average | Revenue Neutrality Adjustment | Policy Results without Charity Care Adjustment | Dollar Amount ($) |
|---|---|---|---|---|---|---|---|---|---|---|
| 210001 | Meritus Medical Center | 6.80% | 7.73% | 8.94% | 8.29% | 8.98% | 8.64% | 0.9844 | 8.50% | 23,444,650 |
| 210002 | Univ. of Maryland Medical System | 7.23% | 7.82% | 9.39% | 9.92% | 9.36% | 9.64% | 0.9844 | 9.49% | 105,640,567 |
| 210003 | Prince Georges Hospital | 13.19% | 14.29% | 15.89% | 13.67% | 15.84% | 14.75% | 0.9844 | 14.52% | 38,211,970 |
| 210004 | Holy Cross Hospital of Silver Spring | 6.82% | 8.35% | 9.06% | 9.64% | 8.36% | 9.00% | 0.9844 | 8.86% | 38,779,866 |
| 210005 | Frederick Memorial Hospital | 5.26% | 6.42% | 7.30% | 6.80% | 6.63% | 6.71% | 0.9844 | 6.61% | 21,400,256 |
| 210006 | Harford Memorial Hospital | 8.81% | 10.59% | 12.15% | 10.35% | 11.92% | 11.13% | 0.9844 | 10.96% | 10,972,905 |
| 210007 | St. Josephs Hospital | 3.18% | 4.53% | 4.98% | 4.41% | 4.80% | 4.61% | 0.9844 | 4.54% | 16,426,010 |
| 210008 | Mercy Medical Center, Inc. | 6.57% | 7.67% | 8.65% | 7.94% | 8.58% | 8.26% | 0.9844 | 8.13% | 34,160,646 |
| 210009 | Johns Hopkins Hospital | 4.86% | 3.84% | 4.69% | 6.40% | 5.28% | 5.84% | 0.9844 | 5.75% | 101,868,948 |
| 210010 | Dorchester General Hospital | 6.25% | 6.98% | 9.34% | 10.44% | 8.30% | 9.37% | 0.9844 | 9.23% | 5,176,199 |
| 210011 | St. Agnes Hospital | 6.43% | 6.89% | 7.85% | 8.25% | 7.17% | 7.71% | 0.9844 | 7.59% | 28,574,996 |
| 210012 | Sinai Hospital | 5.96% | 4.82% | 6.07% | 8.17% | 6.78% | 7.48% | 0.9844 | 7.36% | 46,852,736 |
| 210013 | Bon Secours Hospital | 17.09% | 15.35% | 16.96% | 15.16% | 17.91% | 16.54% | 0.9844 | 16.28% | 20,972,727 |
| 210015 | Franklin Square Hospital | 6.13% | 6.24% | 8.09% | 10.44% | 7.63% | 9.04% | 0.9844 | 8.90% | 39,063,180 |
| 210016 | Washington Adventist Hospital | 7.81% | 9.34% | 10.82% | 9.55% | 9.90% | 9.72% | 0.9844 | 9.57% | 25,401,629 |
| 210017 | Garrett County Memorial Hospital | 6.68% | 9.40% | 12.20% | 10.81% | 10.87% | 10.84% | 0.9844 | 10.67% | 4,326,110 |
| 210018 | Montgomery General Hospital | 5.83% | 5.84% | 6.73% | 6.74% | 6.84% | 6.79% | 0.9844 | 6.68% | 10,475,489 |
| 210019 | Peninsula Regional Medical Center | 5.18% | 6.60% | 7.77% | 6.63% | 7.27% | 6.95% | 0.9844 | 6.84% | 27,801,973 |
| 210022 | Suburban Hospital | 4.37% | 4.91% | 5.25% | 4.48% | 5.15% | 4.82% | 0.9844 | 4.74% | 12,010,326 |
| 210023 | Anne Arundel General Hospital | 3.74% | 4.52% | 5.19% | 4.72% | 4.89% | 4.81% | 0.9844 | 4.73% | 21,824,663 |
| 210024 | Union Memorial Hospital | 4.95% | 6.26% | 7.43% | 7.18% | 6.57% | 6.88% | 0.9844 | 6.77% | 27,112,686 |
| 210027 | Braddock Hospital | 3.58% | 5.59% | 7.34% | 6.36% | 6.17% | 6.26% | 0.9844 | 6.17% | 18,803,641 |
| 210028 | St. Marys Hospital | 6.31% | 5.38% | 6.81% | 9.38% | 6.98% | 8.18% | 0.9844 | 8.05% | 10,804,124 |
| 210029 | Johns Hopkins Bayview | 7.49% | 6.80% | 8.25% | 9.85% | 9.27% | 9.56% | 0.9844 | 9.41% | 49,900,473 |
| 210030 | Chester River Hospital Center | 7.10% | 9.73% | 11.77% | 8.85% | 11.19% | 10.02% | 0.9844 | 9.86% | 6,146,091 |
| 210032 | Union Hospital of Cecil County | 6.81% | 8.63% | 11.14% | 11.79% | 11.07% | 11.43% | 0.9844 | 11.25% | 15,496,245 |
| 210033 | Carroll County General Hospital | 4.51% | 5.25% | 6.54% | 6.39% | 5.57% | 5.98% | 0.9844 | 5.89% | 12,630,994 |

| Hospid | Hospital Name | UCC in Rates (July 1, 2011) | Actual UCC for FY 11 | Adjusted UCC for FY 11 (Includes Averted Bad Debt) | Predicted UCC | FY 09- FY 11 UCC Average | 50/ 50 Blended UCC Average | Revenue Neutrality Adjustment | Policy Results without Charity Care Adjustment | Dollar Amount ($) |
|---|---|---|---|---|---|---|---|---|---|---|
| 210034 | Harbor Hospital Center | 7.30% | 8.42% | 10.84% | 12.56% | 9.65% | 11.11% | 0.9844 | 10.93% | 21,944,912 |
| 210035 | Civista Medical Center | 6.24% | 7.71% | 9.05% | 10.72% | 7.63% | 9.18% | 0.9844 | 9.03% | 10,435,658 |
| 210037 | Memorial Hospital at Easton | 4.52% | 5.56% | 7.21% | 7.38% | 6.05% | 6.71% | 0.9844 | 6.61% | 11,444,207 |
| 210038 | Maryland General Hospital | 11.04% | 11.84% | 13.92% | 14.72% | 12.96% | 13.84% | 0.9844 | 13.62% | 24,953,331 |
| 210039 | Calvert Memorial Hospital | 5.60% | 5.76% | 7.09% | 8.85% | 6.77% | 7.81% | 0.9844 | 7.69% | 9,933,152 |
| 210040 | Northwest Hospital Center, Inc. | 6.63% | 7.44% | 8.81% | 8.66% | 8.87% | 8.76% | 0.9844 | 8.63% | 19,638,840 |
| 210043 | North Arundel General Hospital | 6.67% | 8.87% | 10.00% | 8.61% | 8.96% | 8.79% | 0.9844 | 8.65% | 30,596,812 |
| 210044 | Greater Baltimore Medical Center | 3.28% | 3.08% | 3.59% | 4.86% | 3.37% | 4.11% | 0.9844 | 4.05% | 17,283,575 |
| 210045 | McCready Foundation, Inc. | 8.22% | 14.17% | 17.48% | 12.27% | 14.26% | 13.27% | 0.9844 | 13.06% | 2,381,376 |
| 210048 | Howard County General Hospital | 5.65% | 5.84% | 6.53% | 8.67% | 6.25% | 7.46% | 0.9844 | 7.35% | 18,767,138 |
| 210049 | Upper Chesapeake Medical Center | 5.62% | 6.73% | 7.59% | 7.59% | 7.39% | 7.49% | 0.9844 | 7.37% | 16,685,167 |
| 210051 | Doctors Community Hospital | 7.70% | 7.77% | 9.22% | 8.85% | 9.46% | 9.16% | 0.9844 | 9.01% | 19,206,095 |
| 210054 | Southern Maryland Hospital | 7.00% | 8.47% | 9.59% | 9.56% | 9.05% | 9.31% | 0.9844 | 9.16% | 20,452,801 |
| 210055 | Laurel Regional Hospital | 10.01% | 12.50% | 13.93% | 12.60% | 13.03% | 12.81% | 0.9844 | 12.61% | 13,001,013 |
| 210056 | Good Samaritan Hospital | 4.90% | 5.67% | 6.85% | 7.65% | 6.36% | 7.01% | 0.9844 | 6.90% | 20,977,595 |
| 210057 | Shady Grove Adventist Hospital | 6.27% | 6.32% | 7.35% | 8.59% | 7.15% | 7.87% | 0.9844 | 7.75% | 25,984,100 |
| *210058 | James Lawrence Kernan Hospital | 6.56% | 7.05% | 7.79% | 7.36% | 7.98% | 7.67% | 1.0000 | 7.67% | 7,945,067 |
| 210060 | Fort Washington Medical Center | 10.56% | 13.11% | 14.36% | 15.75% | 14.42% | 15.09% | 0.9844 | 14.85% | 6,645,124 |
| 210061 | Atlantic General Hospital | 5.31% | 6.76% | 8.15% | 7.65% | 7.51% | 7.58% | 0.9844 | 7.46% | 6,578,101 |
| | STATE-WIDE | 6.13% | 6.63% | 7.82% | 8.25% | 7.64% | 7.95% | 0.9844 | 7.82% | 1,079,134,166 |

** Kernan Hospital was excluded in the Regression Analysis, Revenue Neutrality and Charity Care Adjustment Calculations*

**Exhibit 2**
**Summary of the Preliminary Results of the Proposed Recommendation**

| Hospid | Hospital Name | FY 2013 Policy Result w/o Charity Adjustment | FY 2013 Policy Result with Charity Adjustment |
|---|---|---|---|
| 210001 | Meritus Medical Center | 8.50% | 8.57% |
| 210002 | Univ. of Maryland Medical System | 9.49% | 9.59% |
| 210003 | Prince Georges Hospital | 14.52% | 15.07% |
| 210004 | Holy Cross Hospital of Silver Spring | 8.86% | 8.93% |
| 210005 | Frederick Memorial Hospital | 6.61% | 6.56% |
| 210006 | Harford Memorial Hospital | 10.96% | 10.36% |
| 210007 | St. Josephs Hospital | 4.54% | 4.40% |
| 210008 | Mercy Medical Center, Inc. | 8.13% | 8.08% |
| 210009 | Johns Hopkins Hospital | 5.75% | 5.77% |
| 210010 | Dorchester General Hospital | 9.23% | 9.38% |
| 210011 | St. Agnes Hospital | 7.59% | 7.80% |
| 210012 | Sinai Hospital | 7.36% | 7.31% |
| 210013 | Bon Secours Hospital | 16.28% | 16.78% |
| 210015 | Franklin Square Hospital | 8.90% | 8.88% |
| 210016 | Washington Adventist Hospital | 9.57% | 9.58% |
| 210017 | Garrett County Memorial Hospital | 10.67% | 11.19% |
| 210018 | Montgomery General Hospital | 6.68% | 6.96% |
| 210019 | Peninsula Regional Medical Center | 6.84% | 6.80% |
| 210022 | Suburban Hospital | 4.74% | 4.65% |
| 210023 | Anne Arundel General Hospital | 4.73% | 4.61% |
| 210024 | Union Memorial Hospital | 6.77% | 6.84% |
| 210027 | Braddock Hospital | 6.17% | 6.51% |
| 210028 | St. Marys Hospital | 8.05% | 8.12% |
| 210029 | Johns Hopkins Bayview Med. Center | 9.41% | 9.65% |
| 210030 | Chester River Hospital Center | 9.86% | 10.45% |
| 210032 | Union Hospital of Cecil County | 11.25% | 10.89% |
| 210033 | Carroll County General Hospital | 5.89% | 5.74% |
| 210034 | Harbor Hospital Center | 10.93% | 10.94% |
| 210035 | Civista Medical Center | 9.03% | 8.71% |
| 210037 | Memorial Hospital at Easton | 6.61% | 6.64% |
| 210038 | Maryland General Hospital | 13.62% | 13.54% |
| 210039 | Calvert Memorial Hospital | 7.69% | 7.86% |
| 210040 | Northwest Hospital Center, Inc. | 8.63% | 8.34% |
| 210043 | North Arundel General Hospital | 8.65% | 8.48% |
| 210044 | Greater Baltimore Medical Center | 4.05% | 4.02% |
| 210045 | McCready Foundation, Inc. | 13.06% | 12.88% |

| | | | |
|---|---|---|---|
| 210048 | Howard County General Hospital | 7.35% | 7.23% |
| 210049 | Upper Chesapeake Medical Center | 7.37% | 7.04% |
| 210051 | Doctors Community Hospital | 9.01% | 8.58% |
| 210054 | Southern Maryland Hospital | 9.16% | 8.74% |
| 210055 | Laurel Regional Hospital | 12.61% | 12.84% |
| 210056 | Good Samaritan Hospital | 6.90% | 6.86% |
| 210057 | Shady Grove Adventist Hospital | 7.75% | 7.76% |
| *210058 | James Lawrence Kernan Hospital | 7.67% | 7.67% |
| 210060 | Fort Washington Medical Center | 14.85% | 14.04% |
| 210061 | Atlantic General Hospital | 7.46% | 7.21% |
| | STATE-WIDE | 7.82% | 7.82% |

** Kernan Hospital was excluded in the Regression Analysis, Revenue Neutrality and Charity Care Adjustment Calculations*

**Exhibit 3**
**Statistical Summary of the Data Elements and Regression Results**

| **Proposed Methodology** | | | | |
|---|---|---|---|---|
| R-Square | 0.7709 | | | |
| Adjusted R-Square | 0.7602 | | | |
| **Variables:** | **Parameter Estimate** | **Standard Error** | **t Value** | **P-Value (Pr > \|t\|)** |
| The proportion of a hospital's total charges from inpatient non-Medicare admissions through the emergency room | 0.07049 | 0.03436 | 2.05 | 0.0423 |
| The proportion of a hospital's total charges from inpatient Medicaid, self-pay and charity | 0.15278 | 0.03547 | 4.31 | <.0001 |
| The proportion of a hospital's total charges from outpatient Medicaid, self-pay, and charity visits | 0.39646 | 0.06088 | 6.51 | <.0001 |
| The proportion of a hospital's total charges from Non-Medicare outpatient emergency department charges | 0.24729 | 0.04234 | 5.84 | <.0001 |

| **Current Methodology** | | | | |
|---|---|---|---|---|
| R-Square | 0.7837 | | | |
| Adjusted R-Square | 0.7736 | | | |
| **Variables:** | **Parameter Estimate** | **Standard Error** | **t Value** | **P-Value (Pr > \|t\|)** |
| The proportion of a hospital's total charges from inpatient non-Medicare admissions through the emergency room | 0.11522 | 0.03127 | 3.68 | 0.0003 |
| The proportion of a hospital's total charges from inpatient Medicaid, self-pay and charity | 0.15665 | 0.03306 | 4.74 | <.0001 |
| The proportion of a hospital's total charges from outpatient Medicaid, self-pay, and charity visits to the emergency room | 0.78528 | 0.08957 | 8.77 | <.0001 |
| The proportion of a hospital's total charges from outpatient services | 0.07588 | 0.02966 | 2.56 | 0.0117 |

**Exhibit 4**
**Current Policy vs. the Proposed Policy - Difference in Hospital-Specific UCC Rates**

| Hospid | Hospital Name | FY 2013 Policy Result with Charity Adjustment (Current Policy) | FY 2013 Policy Result with Charity Adjustment (Proposed Policy) | Difference |
|---|---|---|---|---|
| 210001 | Meritus Medical Center | 8.72% | 8.57% | -0.15% |
| 210002 | Univ. of Maryland Medical System | 9.14% | 9.59% | 0.45% |
| 210003 | Prince Georges Hospital | 15.51% | 15.07% | -0.44% |
| 210004 | Holy Cross Hospital of Silver Spring | 8.54% | 8.93% | 0.39% |
| 210005 | Frederick Memorial Hospital | 6.76% | 6.56% | -0.20% |
| 210006 | Harford Memorial Hospital | 10.45% | 10.36% | -0.09% |
| 210007 | St. Josephs Hospital | 4.57% | 4.40% | -0.17% |
| 210008 | Mercy Medical Center, Inc. | 8.51% | 8.08% | -0.44% |
| 210009 | Johns Hopkins Hospital | 5.91% | 5.77% | -0.14% |
| 210010 | Dorchester General Hospital | 9.75% | 9.38% | -0.37% |
| 210011 | St. Agnes Hospital | 7.94% | 7.80% | -0.14% |
| 210012 | Sinai Hospital | 7.29% | 7.31% | 0.02% |
| 210013 | Bon Secours Hospital | 16.99% | 16.78% | -0.21% |
| 210015 | Franklin Square Hospital | 8.86% | 8.88% | 0.01% |
| 210016 | Washington Adventist Hospital | 9.80% | 9.58% | -0.23% |
| 210017 | Garrett County Memorial Hospital | 10.82% | 11.19% | 0.37% |
| 210018 | Montgomery General Hospital | 7.11% | 6.96% | -0.15% |
| 210019 | Peninsula Regional Medical Center | 6.86% | 6.80% | -0.06% |
| 210022 | Suburban Hospital | 4.68% | 4.65% | -0.03% |
| 210023 | Anne Arundel General Hospital | 4.85% | 4.61% | -0.23% |
| 210024 | Union Memorial Hospital | 6.91% | 6.84% | -0.07% |
| 210027 | Braddock Hospital | 6.46% | 6.51% | 0.06% |
| 210028 | St. Marys Hospital | 7.71% | 8.12% | 0.41% |
| 210029 | Johns Hopkins Bayview | 8.96% | 9.65% | 0.69% |
| 210030 | Chester River Hospital Center | 10.52% | 10.45% | -0.08% |
| 210032 | Union Hospital of Cecil County | 10.87% | 10.89% | 0.02% |
| 210033 | Carroll County General Hospital | 5.77% | 5.74% | -0.03% |
| 210034 | Harbor Hospital Center | 11.17% | 10.94% | -0.23% |
| 210035 | Civista Medical Center | 8.70% | 8.71% | 0.00% |
| 210037 | Memorial Hospital at Easton | 6.78% | 6.64% | -0.14% |
| 210038 | Maryland General Hospital | 13.39% | 13.54% | 0.16% |
| 210039 | Calvert Memorial Hospital | 8.00% | 7.86% | -0.14% |
| 210040 | Northwest Hospital Center, Inc. | 8.53% | 8.34% | -0.20% |
| 210043 | North Arundel General Hospital | 8.68% | 8.48% | -0.20% |
| 210044 | Greater Baltimore Medical Center | 4.19% | 4.02% | -0.17% |

| Hospid | Hospital Name | FY 2013 Policy Result with Charity Adjustment (Current Policy) | FY 2013 Policy Result with Charity Adjustment (Proposed Policy) | Difference |
|---|---|---|---|---|
| 210045 | McCready Foundation, Inc. | 12.91% | 12.88% | -0.03% |
| 210048 | Howard County General Hospital | 6.85% | 7.23% | 0.39% |
| 210049 | Upper Chesapeake Medical Center | 6.89% | 7.04% | 0.14% |
| 210051 | Doctors Community Hospital | 8.89% | 8.58% | -0.32% |
| 210054 | Southern Maryland Hospital | 8.64% | 8.74% | 0.10% |
| 210055 | Laurel Regional Hospital | 12.67% | 12.84% | 0.17% |
| 210056 | Good Samaritan Hospital | 7.01% | 6.86% | -0.16% |
| 210057 | Shady Grove Adventist Hospital | 7.31% | 7.76% | 0.45% |
| *210058 | James Lawrence Kernan Hospital | 5.82% | 7.67% | 1.85% |
| 210060 | Fort Washington Medical Center | 14.17% | 14.04% | -0.13% |
| 210061 | Atlantic General Hospital | 7.48% | 7.21% | -0.28% |
| | STATE-WIDE | 7.82% | 7.82% | 0.00% |

** Kernan Hospital was excluded in the Regression Analysis, Revenue Neutrality and Charity Care Adjustment Calculations*

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

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

Patrick Redmon, Ph.D.
Executive Director

Stephen Ports
Principal Deputy Director
Policy and Operations

Gerard J. Schmith
Deputy Director
Hospital Rate Setting

Mary Beth Pohl
Deputy Director
Research and Methodology

**TO:** Commissioners

**FROM:** Legal Department

**DATE:** April 25, 2012

**RE:** Hearing and Meeting Schedule

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**Public Session:**

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

July 11, 2012 Time to be Determined, 4160 Patterson Avenue, HSCRC Conference Room

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

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

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