

453rd MEETING OF THE
HEALTH SERVICES COST REVIEW COMMISSION

FEBRUARY 4, 2009

Chairman Young called the meeting to order at 9:04 a.m. Commissioners Joseph R. Antos, Ph.D., Trudy R. Hall, M.D., Kevin J. Sexton, and Herbert S. Wong, Ph.D. were also present.

ITEM I
REVIEW OF THE MINUTES OF THE PUBLIC SESSION
OF JANUARY 14, 2009

The Commission voted unanimously to approve the minutes of the January 14, 2009 Public Meeting.

ITEM II
EXECUTIVE DIRECTOR'S REPORT

Robert Murray, Executive Director, briefed the Commissioners on staff's activities in response to concerns raised about hospitals' credit and collection practices. Mr. Murray stated that the Governor requested that the Commission submit a report that fully evaluated the issues raised and would at a minimum review: 1) the extent to which the policies differ among hospitals; 2) whether hospitals have become more aggressive in their collection efforts over time; and 3) whether there are regulatory or legislative changes required.

Mr. Murray summarized the interim report to the Governor and staff's on going activities to produce a final report. The interim report outlines the issues and provides a background on the rate setting system focusing on the way uncompensated care (UCC) is handled, i.e., how the treatment of uncompensated care is a balancing act between the hospitals' social mission and the expectation that they will be efficient institutions and credit and collect when people can afford to pay. The report discusses the major issues in detail and places them in the context of the current economic environment, as well as noting the federal government's interest in how non-profit hospitals are earning their tax-exempt status. The report also outlines the actions and activities taken to date: 1) proposing regulations; 2) meeting with legislators, the Secretary of Health, and representatives of : the Department of Health and Mental Hygiene; the Attorney General's Office Consumer Protection Division; hospitals; Legal Aid; Maryland Hospital Association (MHA); and credit and collection agencies; 3) reviewing what other states have done legislatively; 4) reviewing the trends in UCC funding and the mix of charity care versus bad debts and whether they can be linked back to credit and collection policies; 5) reviewing and benchmarking credit and collection policies and developing a "best practices" policy; 6) initiating special audits to

determine whether financial assistance and credit and collection policies are being applied consistently; 7) exploring ways of improving communication to patients of their legal rights on unpaid claims; 8) inquiring into the efficacy of creating an intermediate appeals, grievance, or mediation step prior to legal action; 9) reviewing and evaluating the Commission's UCC policy to determine whether there are changes that are warranted, i.e., should we differentiate between charity and bad debts; and 10) assembling a work group to move the hospital industry towards a "best practices" policy in credit and collection activity. In addition, the report will have a series of preliminary recommendations

Mr. Murray announced that Ing-Jay Cheng, of the MHA, has decided to leave MHA and take a position with the Center for Medicare and Medicaid Services (CMS). Mr. Murray thanked Ms. Cheng for her dedication and work and expressed staff's utmost respect for Ms. Chang's professional abilities. Mr. Murray congratulated Ms. Cheng and wished her good luck in her new position.

ITEM III
DOCKET STATUS CASES CLOSED

1985A – University of Maryland Medical Center 2012A - Johns Hopkins Health System
2011R – Baltimore Washington Medical Center

ITEM IV
DOCKET STATUS CASES OPEN

Memorial Hospital at Easton – 2013R

On January 9, 2009, the Memorial Hospital at Easton filed an application requesting a rate for Lithotripsy (LIT) services. The Hospital currently has a rebundled LIT rate and inpatients are transported to an off-site facility for LIT services. However, effective March 1, 2009, the Hospital will begin providing LIT services at the Hospital to both inpatients and outpatients. The Hospital requested the state-wide median LIT rate be approved

After reviewing the Hospital's application, staff recommended:

1. That the LIT rate of \$2,722.83 per procedure be approved effective March 1, 2009;
2. That no change be made to the Hospital's charge per case target for LIT services; and
3. That the LIT rate not be rate realigned until a full year's experience has been reported to the Commission.

The Commission voted unanimously to approve staff's recommendation.

EXTENSIONS

Staff requested a 30 day extension for review of the application of the Greater Baltimore Medical Center, proceeding 2015R.

The Commission voted unanimously to approve staff's request.

ITEM V

DRAFT RECOMMENDATIONS FOR REVISIONS TO THE REASONABLENESS OF CHARGES METHODOLOGY

John O'Brien, Deputy Director-Research and Methodology, stated that it was the intention of staff to present a final recommendation at today's public meeting. However, all parties indicated an interest in running a simulation of the Reasonableness of Charges methodology utilizing the final recommended revisions thereto and up-to-date data before final comments are made. Therefore, Mr. O'Brien asked that hospitals file the necessary information on interns, residents, and fellows to be filed by February 13th so that the simulations can be completed by February 20th. Comments will then be submitted to the Commission's offices by February 26th and a final recommendation will be presented by staff at the March public meeting.

ITEM VI

DRAFT RECOMMENDATIONS ON REVISIONS REGARDING MARYLAND HOSPITAL-ACQUIRED CONDITIONS

A panel consisting of Robert Murray, Diane Feeney, Associate Director-Quality Initiative, John O'Brien, Deputy Director Research and Methodology, Wendy Kronmiller of the Maryland Office of Health Care Quality, in addition to Norbert Goldfield, M.D., Elizabeth McCullough, and Rich Averill of 3M Health Information Systems, presented staff's draft recommendation on Maryland Hospital-Acquired Conditions (MHACs) methodology.

In his overview of the recommendation, Mr. Murray stated that one focus of this initiative is on highly preventable complications that are measurable. The other focus is on the Commission's statutory mandate to certify that rates are based on reasonable costs. It is staff's presumption that highly preventable complications that can be prevented in the vast majority of cases do not constitute reasonable costs. Staff's interpretation is that the Commission has a legal mandate to implement a policy of this nature. The presence of secondary diagnoses that are highly preventable create additional payments and reward hospitals for poor quality. In addition to these unintended payment incentives there is a lack of analytic and data tools for hospitals to improve quality. The objective of this initiative is to improve the incentives and provide the hospitals with

analytic tools and data to improve quality.

Mr. Murray noted that although the Commission has made some limited progress on quality improvement, the progress has been limited and slow. It has taken five years to develop a quality based reimbursement effort using process measures. The focus has been on performance measures, with limited linking of performance to payment. There has been virtually no activity on outcome measures, and tools to measure broad-based improvement are limited.

Mr. Murray asserted that the Commission is compelled to act because of its statutory mandate. There is an urgent need to adopt appropriate incentives to correct this reimbursement flaw. We must shift the focus away from the complications that are less preventable toward the cases with complications that are 90%, 95%, or 99% preventable. In doing so, we hope to reduce unnecessary cost, unnecessary patient suffering, and improve quality. Mr. Murray listed the factors compelling the Commission to act now: 1) there are new tools to measure quality; 2) the CMS initiative has made preventable complications initiatives the “law of the land” in every state but Maryland; 3) Maryland is uniquely positioned because of its all-patient severity adjusted APR-DRG system to be a national leader; 4) in Maryland, there is a bias against hospitals with low complication rates because of the zero sum nature of our rate system; 5) the ability to target the Commission’s efforts in areas of reducing waste, in the face of huge budgetary shortfalls nationally and in Maryland, rather than waiting for arbitrary revenue cuts; and 6) the long overdue need to focus on quality improvement.

Mr. Murray summarized the objectives, principles, and approach to the MHAC initiative. Mr. Murray detailed the reasons that Maryland is uniquely positioned to undertake this quality initiative: 1) its extensive data-infrastructure and the analytic capability within the industry and best administrative data set in the nation; 2) availability of the severity adjusted ARP-DRG product, which provides the ability to make use of the new measurement tools afforded by the present-on-admission (POA) coding and the potentially preventable complications (PPCs) development tool; 3) the broad applicability and use of incentives across all-payers and hospitals because of the Medicare waiver, which allows Maryland to craft a local solution. Maryland’s unique rate setting system decouples payment from actual case payments, as opposed to Medicare’s per case payment system in which decrements are related to a particular case. This produces a more equitable result because hospitals are paid for resources used, which reduces the potential for access concerns, and incentives (revenue increases or decrements) are applied at an overall revenue level in order to influence overall processes in hospitals. Although the magnitude of the incentives is quite small (0.1%), it will create a behavioral response from hospitals.

The objective is to craft a Maryland based solution, specific to Maryland’s characteristics and regulatory structure. We should follow CMS’s lead and apply Maryland’s unique strengths. The system should be prospective, with an emphasis on data efficacy, data exchange, and transparency, i.e., the ability to monitor and track performance over time. The overall goal is to reduce complication rates and to address the Commission’s mandate to set rates based on reasonable costs. This differentiates this initiative from the Quality Based Reimbursement Initiative, removes unintended incentives and the flaws in current reimbursement, and reduces the bias against hospitals with lower complication rates.

Staff's approach is not untested as alleged by MHA. Staff approach is: 1) to establish appropriate incentives to change hospital behavior (which the Commission has done many times in the past); 2) to provide incentives that are focused on quality improvement by providing analytic tools; 3) to ensure that the incentives are sufficient to change behavior; and 4) to structure the incentives to reflect the hospital's ability to influence complication rates (which are broad based unlike those of CMS which are 100% payment decrements). Finally, the initiative has built-in incentives for continued reporting of complications. This is a targeted approach to reduce waste and unnecessary cost as opposed to an arbitrary imposition of cost cutting that may come in this era of budgetary constraints. This will also allow the HSCRC to achieve a leadership role in quality improvement. Mr. Murray urged the Commission to act favorably on the recommendation.

Diane Feeney stated that hospital data, communication, feedback, and transparency are critical to successful implementation of MHACs. Ms. Feeney reported that accurate coding of the POA indicator is central to the use of MHACs. Staff is providing feedback on an ongoing basis to improve POA data. The HSCRC has convened a MHAC Payment Policy Workgroup, comprising the hospital industry and payers, including Maryland Medicaid, to provide important input on content and approach to statewide vetting of MHACs and to maximize transparency. This is particularly important given that hospitals have been provided access to the complete definitions manual and exclusion and assignment logic of the MHACs, as well as hospital-specific case assignment reports since December 2008. Hospital feedback on specific findings in their case reports has allowed the Commission to refine and revise the MHAC case reports. Among other items, hospital feedback led to the removal of 2 of the PPCs as candidates for MHACs. Ms. Feeney stated that the workgroup will continue to refine the process.

Dr. Goldfield and Ms. McCullough summarized the MHAC Initiative's PPCs methodology developed specifically for our APR-DRG Payment System. Dr. Goldfield defined PPCs as harmful events that may result from the process of care and treatment rather than from a natural progression of the underlying disease. The assumptions of the methodology are that: 1) not all inpatient complications are preventable; 2) even with optimal care inpatient complications will occur; therefore, detailed global and condition-specific exclusions (which are open for examination and ongoing improvement) have been implemented for each of the twelve MHACs; 3) patients who have had problems with quality of care will be more likely to have an inpatient complication; and 4) hospitals with quality of care problems will have higher rates of inpatient complications.

Dr. Goldfield emphasized that the development of PPCs requires the availability of the POA indicator. The POA enables us to identify post admission events that represent a complication; however, we must also identify the clinical circumstances under which the complication is potentially preventable. This is done by panels of clinicians under the auspices of 3M. Dr. Goldfield noted since the New York State Department of Health has reported, confidentially, the rates of all the PPCs by hospital, feedback from other clinicians has been critical in terms of the ongoing evolution and improvement of the PPCs. Dr. Goldfield stated that the PPCs developed by 3M are much more inclusive than others, because there are numerous PPC specific clinical exclusions and extensive risk adjustments built into the PPC list. Both the PPC and the exclusion

logic use information from the current base admission APR-DRG assignment and are updated annually with the APR-DRG annual update. The PPC system was purposely designed so that patients who come in with multiple co-morbidities will have the PPC recognized but likely will have no payment decrement. In terms of global exclusions, there are groups of patients that are immediately excluded because the probability of complications is much higher, and their preventability is uncertain. They include: major trauma, organ transplants, major or metastatic malignancy, cardiac arrest, HIV, and specific burns. Of 13,367 ICD- diagnoses codes, 1450 have been identified as PPC diagnoses. Each PPC diagnosis was assigned to one of 64 mutually exclusive PPC groups based on similarities in clinical presentation and impact. In addition, a select set of ICD-9 codes was also used to identify some PPCs.

Dr. Goldfield discussed in detail the twelve highly preventable complications that make up the MHACs Initiative and their FY 2008 statewide frequency. Dr. Goldfield emphasized that the PPCs not globally or clinically excluded were “low hanging fruit” and are truly highly preventable.

Dr. Goldfield stated that continuous quality improvement tools such as PPCs should have an improvement process. This is ongoing with the PPC system and has occurred through feedback from both the New York Department of Health and clinician groups, as well as from Maryland hospitals.

Rich Averill and John O’Brien outlined the development of the proposed payment methodology. Mr. Averill noted that DRG based payments place hospitals at financial risk for use of bed days and ancillary services; by implementing MHACs, all we are doing is placing hospitals at risk for the cost of a very narrow and selected number of complications. This initiative represents a direct and logical extension of the fundamental premise of the DRG payment system. We are bundling services together and setting a fair and reasonable payment rate. Hospitals will be rewarded if they are more efficient and will suffer financial consequences if they cannot provide care efficiently. Mr. Averill observed that the financial risk associated with MHACs is very minor relative to the financial risk already in the system, and when compared with national trends towards hospitals being at financial risk for much broader payment bundles. Mr. Averill asserted that evidence shows that payment incentives do change behavior.

Mr. Averill noted that instead of removing the entire payment implications associated with the complication as in the Medicare policy, the MHAC system has the flexibility to remove a portion of the payment associated with a complication. This flexibility recognizes the fact that complications are not 100% preventable. In the context of the Maryland rate system, what is essentially a state-wide budget is set, and DRGs determine how the budget is divided among the hospitals. If the MHAC system is approved, the effect will be to shift money from hospitals that have high complication rate, relative to these MHACs, to hospitals with low complication rates. Thus, the combination of DRGs and MHACs is a way of allocating a fixed budget as fairly as possible. MHACs determine the circumstances under which a post-admission complication will be allowed to increase payment. Payment is affected only if the MHAC is the only reason a patient is assigned to a higher severity level, primarily patients admitted with severity levels I and 2. Coupled with global and clinical exclusions, the requirement that the patient is assigned to a

higher severity level because of the MHAC decreases significantly the percentage of cases identified.

John O'Brien summarized the development of the MHAC adjustment of allowable charges policy. When it comes time to look at the payment system, the MHAC adjustment is made at the end of the year to a hospital's overall allowable charges. Discussions have been held with hospital representatives, payers, and consultants to review various approaches to adjusting allowable charges and to help ensure consistency with methods currently used in the system and preventing unintended consequences. Staff has developed two adjustments to approved charges. The first is used if there is a change in the APR-DRG assignment because of the MHAC. In that instance, the case weight will be lowered by 90% of the difference between the old higher case weight and the new lower weight. The second is used if the case had outlier charges not accounted for in APR-DRG weights. In that instance, the allowable charges will be adjusted by 90% of the charges associated with the MHAC based on a regression analysis. The reason that only 90% is removed is to recognize that not all the complications are preventable. Removing only 90% of the payment increase associated with MHAC procedures also provides an incentive for hospitals to code MHAC procedures, since if the procedures are not coded, the hospital will lose 100% of the increase associated with the MHAC. Mr. O'Brien noted that over 75% of the cases with an MHAC result in no adjustment. Based on FY 2008 simulations, the overall impact of MHAC adjustments to allowable charges would have been 0.12% (\$9.36 million), and the reduction to allowable charges of MHAC discharges only, is 6.84% .

Ms. Kronmiller stated that the Office of Health Care Quality (OHCQ) has a mandatory incident reporting program that requires hospitals to report deaths and serious injuries that result unexpectedly from treatment. This data are accumulated, and a report is issued which analyzes these incidents and provides constructive feedback to hospitals. There are no penalties assessed if hospitals report incidents; however, there are penalties for not reporting. Since OHCQ does not conduct routine inspections, the question becomes how to find out if hospitals are not reporting incidents. Currently, the OHCQ must rely on patient complaints. Since everyone has an interest in cost benefits and benefits to consumers, the hope is that HSCRC's and OHCQ's efforts will coalesce. By providing the OHCQ with access to MHAC data, the OHCQ will learn about unreported incidents and can investigate and provide feedback to the HSCRC about the cases. Ms. Kronmiller and Ms. Feeney provided several examples of how the systems can work together based on information of incidents as provided by the HSCRC.

Mr. Murray summarized the main points of the MHAC initiative: 1) the HSCRC has a statutory requirement to establish reasonable costs; 2) unlike CMS-HACs, the MHAC initiative focuses on the overall operations of the hospital and provides appropriate incentives to code complications; 3) the minimal magnitude of revenue reduction reflects the conservative nature of the initiative; 4) the initiative provides a responsive and targeted approach to budgetary constraints; 5) the initiative addresses a flaw in the reimbursement system and the bias against with hospitals with lower complication rates; 6) hospitals more successful in preventing complications improve quality and free-up rate capacity; 7) there are no access concerns since the payment per case is unchanged; 8) these initiatives appear to stimulate more research not less; and 9) the reduction of preventable complications is not left up to an unenforceable form of voluntary regulation.

Mr. Murray urged the prospective implementation of the MHAC Initiative, effective April 1st, and to approve staff's recommendation as presented. Mr. Murray stated that staff has attempted to show that there is a human dimension to the initiative and that it can help prevent tragic circumstances. Mr. Murray stated that staff intends to present the final recommendation at the March public meeting.

A panel consisting of Carmela Coyle, President of the Maryland Hospital Association, Ray Grahe, Vice President –Finance of the Washington County Health System, Larry L. Smith, Vice President-Risk Management of MedStar Health, and Peter Pronovost, M.D., Medical Director for the Center for Innovations in Quality Patient Care, presented the hospital industry's comments on the proposed recommendation.

Ms. Coyle stated that MHA and the hospitals it represents continue to support linking payment to performance when the original principles that provided the foundation for quality-based reimbursement are met. The industry's concern about the 3M methodology is that it takes those principles and makes a "left-hand turn." As we began out with quality-based reimbursement, the objective was to make certain that poor performers were assisted. It was about raising performance in the State; however, staff's approach does not assist poor performers - - it penalizes them. In terms of quality-based reimbursement, we always spoke about the need that it be evidence-based. The 3M methodology is not evidence-based. It is a statistical model. The industry believes that it is extremely important that these methodologies be tested and well understood before being linked to payment. There are concerns about hurrying the enactment of this proposal. It appears to be driven by budget concerns rather than by performance improvement concerns. As to involving stakeholders in its development, while there have been many invitations to participate, the industry has not received the information timely. Nevertheless, the methodology that has been proposed is very interesting and one that the industry would like to take a more in-depth look at. The industry is not opposed to linking payment and performance, nor necessarily opposed to the 3M methodology, although the industry would like to take some time to examine it. It is opposed, however, to linking payment to that specific methodology at this point in time.

Dr. Pronovost stated that he was encouraged by our common goal of improving care and reducing cost in Maryland. Dr. Pronovost noted that the National Health Care Quality report showed that progress in safety over the last decade has been pretty poor. And, what is most striking, is that we do not know how to measure outcomes; they are not even on the radar screen. Contrast that performance to the advances that we've made in biomedical science over the same time, where we sequenced the human genome; where AIDS is a chronic disease; and where we can cure most childhood leukemias. The difference is that we approached biomedical as science, and in health care quality, we put policy before the science. We are because of that. For example: wrong site surgery, operating on the wrong side of the body is devastating; it ends up in the papers. The approach taken was to establish a national standard, and that standard was made with a really superficial understanding of what the problem was, with no evidence that it would work, and with absolutely no measure to evaluate its effectiveness. Wrong site surgery has increased yearly since that policy went in place. According to Dr. Pronovost we ran before we understood

the problem. We all agree that these complications should be both measurable and preventable. However, the devil is in the details. What do we mean by being transparent, not just on the codes that go to make these measures, but how accurately we can measure them, and how sure we are that they are preventable.

For example, retained foreign body after surgery is likely coded quite well on discharge data. And hospitals shouldn't be paid for those complications because they shouldn't happen. On the other hand, there is probably over a 50% error rate in measuring catheter related blood infections and yet right down the hall, the Maryland Health Care Commission has accurate state of the art data to measure them. Why then would we think of using discharge data for these infections when we know it is going to be wrong half of the time when we have more standardized definitions? Another example is deep venous thrombosis; although it is not on our list, it is on the CMS list. Rates in our institution increased tenfold over a very short period of time. Why did they go up? Because our Doctors believed that screening for these infections was a marker of high quality care (and there is some evidence that it is), so they started routinely looking for and finding them, and their rates went up tenfold. To get a valid measure, you need clear definitions and you need a surveillance standard; without both, you are going to have more noise than signal. According to Dr. Pronovost, can you imagine setting your reimbursement policies when costs can vary tenfold by how hard you look for something?

In thinking about preventability, there is no doubt that we all want to prevent harms; physicians went wrong for years because for years we've labeled only egregious examples of harms as preventable. If inevitable and preventable complications are lumped together, they are difficult to separate. However, if you can cull out the preventable complications you can work with them. The physician's view of preventable complications was far too limited; now the pendulum has swung in the opposite direction - - all harm is preventable. We need to find some way to allocate which complications are preventable and which are inevitable.

Dr. Pronovost posited that there are three approaches. The first is that they are all preventable. For example, it may be true that all cases of retained foreign bodies are preventable. That clearly fits the model of: there was an error and it led to harm; and the inverse that if the error were eliminated, there is no harm. And, perhaps, we shouldn't be paid for that. However, even in the catheter related infection work that we won the accolades for, we didn't eliminate all infections. We reduced them by 66 percent, but they are still happening. And that occurred without reporting and without pay for performance.

The second way to classify complications is to adjust for which complications are preventable, which is the proposed methodology. Dr. Pronovost expressed concern with a methodology that compares how often a complication is observed to how often it happened in the past. Dr. Pronovost thinks it's erroneous to equate the not expected with when an error actually occurred, because we don't have evidence that that link has been made. Dr. Pronovost has not seen it motivate performance because those who perform well typically say the model looks great and they pat themselves on the back. Those who perform poorly discredit this as a black-box risk adjustment model. They are probably correct according to Dr. Pronovost. We ought to be transparent about what estimates we are using. If 66% of catheter related infections are what we

set the threshold to be, the public ought to know that. If 100% of retained foreign bodies are preventable the public ought to know that. But, we ought to be disciplined, science based, and we must hold ourselves accountable.

The last method is the one that Dr. Pronovost believes offers the most promise in this gray area (where some complications are preventable and some are not) is to link the error with the outcome, i.e., if indeed the error occurred and led to an adverse outcome. In those cases, we should not be paid. For example, if I didn't give antibiotics on time and the patient acquired a surgical site infection, then don't pay me for it. There is evidence that I did not give the antibiotic. Does this method make our work harder? Certainly it does, but we don't really have any estimate as to whether surgical site infections are 100% or 10% preventable. Until we get that data, we are likely to make mistakes. There is no doubt that financial incentives drive behavior. The question is whether it is going to drive wise behavior. In the complication of tracheotomy infection, there is just no logic for what error occurred. The premise is that preventable harm means an error occurred and there was harm, and the inverse if the error was removed then there would be no harm. But Dr. Pronovost does not think we should be incentivizing when we do tracheotomies, because there is pretty good data that doing them early and doing more of them is more comfortable for the patient, gets them out earlier, and is more beneficial. We have to be cautious about what incentives we create because the goal has to be to drive behavior and to align payment with wise behavior.

Dr. Pronovost thinks we have an enormous opportunity for our State to take the national lead. The country is screaming for wise approaches to linking quality to payment, and we have all the right players here in Maryland. However, we have a table of these complications where we have transparently and explicitly disclosed how accurately they were measured to the gold standard, and how much they are preventable, it appears to be premature to attempt to make policy. Perhaps, Dr. Pronovost suggested, we might start with a subset of these complications. Dr. Pronovost stated that the MHCC has valid data on some of the infections, and we may be able to virtually eliminate them. That is probably a good place to start. As far as the other complications, we should be cautious. But what we have learned from the wrong site surgery situation and a decade of working on quality that there is no shortcut to science.

Larry Smith stated that no one can dispute the goals being sought by this proposal; however, after reviewing the material provided by the HSCRC, MedStar's clinical staff concluded that a high percentage of the specific case information represented complications that were not preventable. Therefore, to penalize hospitals by withholding reimbursement simply because these complications arise would be both unfair and unjustified. Adopting such an approach may also result in unwelcome consequences such as negatively impacting efforts to attract and retain physicians. Mr. Smith asserted that judgments pertaining to clinical practice should be made by trained medical professionals rather than by paraprofessionals utilizing a proprietary product that has not been vetted by clinicians. According to Mr. Smith, to the extent that a list of preventable complications becomes codified by the HSCRC, it can be expected that the occurrence of one of these events will be treated by the courts as evidence of malpractice. In addition, this approach, rather than building a culture of safety, will be seen by physicians and other providers as a method of finding fault and fixing blame. Mr. Smith recommended that, at the very least, the

Commission should delay the implementation of the initiative until, as Dr. Pronovost suggested, more research can be done, or we substitute a program that targets the issue that we and our medical staff agree are truly preventable, and then hold us accountable for them.

Ray Grahe stated although he applauds the initiative to improve the quality of Maryland hospitals, there are some flaws in the methodology, e.g., certain PPCs are problematic, differences in groupers, multiple versions of data, all of which speaks to the fact that this is an incomplete methodology that bears further investigation. This methodology is not ready to be rolled out as a payment methodology today. Mr. Grahe presented several hypothetical cases to illustrate his point that a coding-based payment methodology cannot differentiate between the preventability of complications in complex cases with various levels of patient vulnerability. Mr. Grahe advocated a change in payment based on evidence-based review that demonstrates a deviation from a standard of care that led to an outcome that was preventable; was within the hospital's control; was the result of a mistake by the hospital; and resulted in enhanced payment to the hospital. Mr. Grahe also suggested the clinical review of approximately six of the MHACs, and that the data provided hospital be improved so that appropriate analysis can be undertaken. As proposed, the initiative would lead to a payment system with unintended consequences. Mr. Grahe stated that this initiative should be moved to the Patient Safety Center rather than implement an outright payment decrement.

Ms. Coyle applauded HSCRC staff and 3M for the thought and work put into this proposal; however, the industry would like to make several suggestions. MHA recognizes that pressure is on all of us because of CMS's move to limit payment for hospital acquired conditions. However, that methodology has not yet been tested. The industry believes that we would all be better served if the Maryland initiative underwent similar testing and research and analysis. Also, the industry believes that the 3M methodology is very interesting, but that it is in its infancy. We need to test the adequacy of the 3M approach and whether or not this is the right approach for Maryland. In addition, we need to convene a broader discussion in terms of the direction of quality and patient safety in the State of Maryland. The MHA desires that conversation in order to establish the right direction for us, here in Maryland.

Ms. Coyle stated that Secretary Colmers, Bob Murray, Marilyn Moon, Chairman of the MHCC, Rex Cowdry, Executive Director of the MHCC, and Dr. Pronovost have all agreed to participate in this conversation. We all share the same objective.

Ms. Coyle supported Mr. Grahe's suggestion that this might be an appropriate methodology to test within the context of the Maryland Patient Safety Center. According to Ms. Coyle, the Safety Center was designed to do just this, to learn from mistakes, to prevent them from happening again, and to keep us here in Maryland at the cutting edge.

Ms. Mary Musman, representing the Department of Health and Mental Hygiene, reported that because of the national Medicare/Medicaid quality initiative, Maryland Medicaid has received a

letter from CMS asking what they are going to do to catch up with their peers. Half of the State Medicaid programs are piggybacking onto the Medicare methodology. Maryland Medicaid believes that the proposed Maryland Quality Initiative is superior and is preferable to the Medicare methodology; however, if the Maryland Initiative is not implemented, Maryland Medicaid will be forced to adopt the Medicare methodology. Ms. Musman expressed Maryland Medicaid's support for the proposed initiative.

Hal Cohen, Ph.D., representing CareFirst and Kaiser Permanente, urged the Commission to move forward with this initiative on April 1st. Dr. Cohen stated that he and CareFirst urged that the Commission build-in incentives for improving quality of care in 2000. Also, the payers have made it very clear in the 3-year arrangement negotiations that the saving from this initiative is part of the savings that would be generated from the system. Dr. Cohen observed that it appears that MHA wants a standard of proof applied, to what hospitals should not be paid for, to be significantly higher than the standard of proof for what hospitals should be paid for.

Barry Rosen, representing United Healthcare, endorsed staff's recommendation on behalf of United Healthcare. The Commission has an opportunity, because of the all-payer system and the revenue ceiling that is produced by the case-rate target system, to provide incentives to decrease preventable complications and increase quality of care. Call this a pilot program, but give it a try. If in fact it does not result in less hospital acquired complications, throw it out. But if it does result in less hospital acquired complications, Maryland will have achieved what everyone else is just talking about.

Dr. Trudy Hall voiced concerns about some of the specific potentially preventable complications proposed as MHAC.

Dr. Hall also raised a general concern about a potential unintended consequence for the academic/teaching hospitals because medical students, interns or residents may perform less procedures if the hospital would be financially penalized for complications that occur while they are in training; this could result in less trained physicians. This issue could also have greater negative impact for small teaching hospitals which may be forced to close their teaching programs if there are financial implications for certain complications. Foreign medical graduates may be particularly affected if smaller teaching programs close.

In addition, Dr. Hall raised the issue of the severe shortage of OB/GYN physicians in the state as a result of the increasing cost of malpractice insurance. Factors, such as patients' lack of insurance and the poor having no prenatal care, render patients at higher risk when they present for delivery. The PPCs involving 3rd or 4th degree lacerations during child birth, could result in OB/GYNs performing episiotomies unnecessarily or by performing more caesarean sections, thereby increasing resource use and cost. Dr. Hall noted that decreasing payment for complications can make the OB/GYN shortage worse.

Dr. Hall noted that because there are increasingly resistant strains of infections, the PPCs relating to infection rates may cause even greater antibiotic use, further worsening the problem of resistant infections.

Dr. Hall raised the question of what timeframe that the POA was accounting for, e.g., the first 24, 48, or 72 hours? Dr. Hall added that, for the POA indicator to be valid, the diagnostic tests must be sufficient for the initial diagnoses; the patient's clinical signs and systems must be present; and the patient's history must be known.

Dr. Hall suggested that the Commission consider moving forward with a very limited number of MHACs that are truly highly preventable, using Maryland clinicians to continue to craft a Maryland solution, and potentially looking at other vendors and processes.

Mr. Murray noted that it is obvious that there are significant areas of agreement and also significant areas of disagreement. Staff believes that although science is important, the question is what level of exact science must be achieved. Mr. Murray agreed that a broader discussion would be useful, but discussions should not be used as a tactic for delay. Mr. Murray stated that the urgency to implement this initiative do not arise from budgetary consideration or the fact that CMS has implemented a program, the urgency is because of the suffering of the patients who are having these preventable complications. Mr. Murray suggested that the Commission reach out to Dr. Pronovost and others to attempt to resolve the areas of perception and disagreement.

ITEM VII **LEGAL REPORT**

Regulations

Final Adoption

Fee Assessment for Financing Hospital Uncompensated Care - COMAR 10.37.09.01-.04 and .06

The purpose of this action is to provide for full pooling of uncompensated care among all hospitals.

The Commission voted unanimously to approve the final adoption of this amended regulation.

Rate Application and Approval Procedures – COMAR 10.37.10.26-2

The purpose of this action is to describe the assessment process authorized by Ch. 7, Acts of

2007 Special Session, and associated with averted uncompensated care. This action also authorizes penalties for untimely or underpayment of the assessment.

The Commission voted unanimously to approve the final adoption of this new regulation.

Submission of Hospital Outpatient Data Set to the Commission – COMAR 10.37.04.01-.07

The purpose of this action is to expedite the reporting process for outpatient data and thereby avoid unnecessary delay in the Commission’s continuing to obtain information that is invaluable towards promoting greater efficiency in the provision of outpatient services.

The Commission voted unanimously to approve the final adoption of this amended regulation.

Submission of Hospital Discharge Data Set to the Commission – COMAR 10.37.06.01-.05

The purpose of this action is to expedite the reporting process for discharge data and thereby avoid unnecessary delay in the Commission’s continuing to obtain information that is invaluable towards promoting greater efficiency in the provision of hospital care.

The Commission voted unanimously to approve the final adoption of this amended regulation.

ITEM VIII
HEARING AND MEETING SCHEDULE

March 4, 2009	Time to be determined, 4160 Patterson Avenue, HSCRC Conference Room
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April 15, 2009	Time to be determined, 4160 Patterson Avenue, HSCRC Conference Room
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There being no further business, the meeting was adjourned at 11:56 a.m.

