459th MEETING OF THE HEALTH SERVICES COST REVIEW COMMISSION

PUBLIC SESSION OF THE
HEALTH SERVICES COST REVIEW COMMISSION

August 5, 2009

9:30 a.m.

1. **Review of the Executive and Public Minutes of July 1, 2009**

2. **Executive Director's Report**

3. **Docket Status - Cases Closed**

   2028A - University of Maryland Medical Center
   2030R - Peninsula Regional Medical Center

4. **Docket Status - Cases Open**

   2031R - Garrett County Memorial Hospital
   2033N - Baltimore Washington Medical Center
   2034A - University of Maryland Medical Center
   2035R - Carroll Hospital Center

5. **Update on Maryland Hospital Acquired Conditions Vetting Sessions**

6. **Draft Recommendations on Hospital Assessment in Lieu of Medicaid Day Limits from Board of Public Works Approved Budget Reductions**

7. **Final Recommendation for Funding of MHCC Approved Implementation of a Statewide Health Information Exchange**

8. **Addition to reporting Requirements - Denials for Medical Necessity**

9. **Legal Report**

10. **Hearing and Meeting Schedule**

IN RE: THE FULL	*	BEFORE THE HEALTH SERVICES	
RATE REVIEW OF	*	COST REVIEW COMMISSION	
GARRETT COUNTY	*	DOCKET:	2009
MEMORIAL HOSPITAL	*	FOLIO:	1840
GARRETT COUNTY, MARYLAND	*	PROCEEDING:	2031R

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STAFF RECOMMENDATION

August 5, 2009

I. INTRODUCTION

Garrett County Memorial Hospital ("GCMH," or "Hospital") has operated under the HSCRC's Total Patient Revenue (TPR) System for some time. Under the TPR System, the Hospital is provided a fixed revenue (CAP) amount under which it must operate each year. The CAP is updated each year for inflation based on the same inflation factor applied to all other hospitals. The CAP is also adjusted each year for a change in the Hospital's payer mix and approved uncompensated care (mark-up), as is the case with all other hospitals. However, the Hospital does not receive an adjustment for actual case mix change or an adjustment for actual volume changes as other hospitals. Instead, the CAP is increased based on a fixed adjustment for volume changes each year. The volume adjustment provides the Hospital with the lesser of 25% of the percentage change in the population of the county, or a flat 1% increase, whichever is less. The TPR System attempts to deter unnecessary admissions by providing the Hospital with an incentive to control both the charge per inpatient case and the number of cases.

II. THE HOSPITAL REQUEST AND JUSTIFICATION

The Hospital has requested a 5.98% increase to its permanent total revenue (CAP), effective July 1, 2009. The request consists of a 7.11% increase for all inpatient and outpatient revenue included in the Comprehensive Charge Target (CCT) analysis (i.e., the combined inpatient CPC and outpatient CPV analysis), and a 2.89% increase for all other outpatient revenue excluded from the CCT.

III. HOSPITAL RATE HISTORY

GCMH normally receives the same industry-wide adjustments for inflation and Quality Based Reimbursement scaling as do all other hospitals. However, as noted above, the Hospital does not receive the same adjustments for case mix and volume change as do all other hospitals. Although the Hospital does not operate under either the HSCRC's inpatient Charge per Case (CPC) System or outpatient Charge per Visit (CPV) System, the HSCRC staff annually imputes

the Hospital's actual CPC and CPV for each fiscal year. The combined CPC and CPV are used in the HSCRC's Reasonableness of Charges (ROC) analysis. The Hospital was 14.22% below its peer group average on the ROC released in April 2009. The Hospital filed a full rate application on May 4, 2008 and was granted an additional 6.17% increase to its revenue CAP effective June 4, 2008.

IV. HOSPITAL FINANCIAL SITUATION

The Hospital's fiscal year end is June 30. For the past three fiscal years, the Hospital has reported the following audited operating results:

Garrett County Memorial	Net Operating Revenue (Regulated)	Net Operating Profit/(Loss) (Regulated)	Operating Margin (Regulated)	Net Profits
FYE June 2008	$27,996,929	($383,618)	-1.37%	$573,525
FYE June 2007	$27,934,200	$897,400	3.21%	$885,100
FYE June 2006	$26,512,400	$951,400	3.59%	$1,517,600

For the nine months ending March 31, 2009, the Hospital has reported an Operating Profit of $1,282,862, or 4.91%, and an overall Net Profit of $543,444, or 2.13%.

V. STAFF ANALYSIS

A. Effective Date

The Hospital has requested an effective date of July 1, 2009 for the implementation of its rate request. Under Commission law, the effective date of a non temporary rate application must be at least thirty days after the date on which a properly submitted application is filed. The staff recommends the increase to rates to be effective July 1, 2009.

B. Calculation of Inpatient and Outpatient CCT Revenue

In analyzing the Hospital's rate request, the staff applied the ICC methodology based on the Hospital's imputed CCT . This resulted in a 7.41% increase to the approved inpatient and

outpatient revenue that would normally be included under the CCT.

C. Calculation of Outpatient Rates

Outpatient rates for the Hospital were established per the ICC methodology by calculating median rates by outpatient revenue center. These rates, applied to the Hospital's actual volumes, resulted in an 0.58% decrease to the approved outpatient capped revenue. The combined inpatient and outpatient revenue change resulting from the application of the ICC methodology is 5.28%.

VI. FINAL RATES SUMMARIZED

Based on the HSCRC's ICC methodology, and allowing for adjustments deemed appropriate based on the unique circumstances presented by the Hospital, staff recommends the following:

1. That the Hospital be allowed to remain on the HSCRC's Total Patient Revenue (TPR) System;

2. That the Hospital's Total Patient Revenue CAP be set at $37,881,540;

3. That the increase in the CAP be effective July 1, 2009;

4. That the Hospital's rates continue to be adjusted as in the past.

The total revenue CAP of $37,881,540 represents a 5.28% increase to the Hospital's current CAP of $35,981,038.

Garrett County Memorial Hospital Exhibit 1

Effective: July 1, 2009

Summary of Revenue Change

	CCT (Imputed)	Cases	Revenue	HS	
Current CCT Revenue	$5,854	4,510	$26,401,968		
Current Outpatient TPR Revenue				$9,579,070	
Current Total TPR Revenue				$35,981,038	
Recommended CCT Revenue	$6,287	4,510	$28,357,921		7.41%
Recommended Outpatient TPR Revenue				$9,523,619	-0.58%
Recommended Total TPR Revenue				$37,881,540	5.28%
Requested CCT Revenue	$6,266	4,510	$28,260,802		7.04%
Requested Outpatient TPR Revenue				$9,873,529	3.07%
Requested Total TPR Revenue				$38,134,331	5.98%

IN RE: THE PARTIAL RATE	*	**BEFORE THE HEALTH SERVICES**	
APPLICATION OF	*	**COST REVIEW COMMISSION**	
BALTIMORE WASHINGTON	*	**DOCKET:**	**2009**
MEDICAL CENTER	*	**FOLIO:**	**1843**
GLEN BURNIE, MARYLAND	*	**PROCEEDING:**	**2033R**

*** ***

Staff Recommendation

August 5, 2009

Introduction

On May 27, 2009, Baltimore Washington Medical Center (the Hospital) submitted a partial rate application to the Commission requesting new rates for Labor & Delivery (DEL), Obstetrics (OBS), and Nursery (NUR) services. The Hospital is requesting the new rates as a result of its receiving CON approval to construct an Emergency Room and Obstetrics tower on November 22, 2005. The Hospital is requesting the current statewide median rate effective July 1, 2009.

Staff Evaluation

To determine if the Hospital DEL, OBS, and NUR rates should be set at the statewide median or at a rate based on its projected costs, the staff requested that the Hospital submit to the Commission its cost and volume projections for FY 2010. Based on the Hospital's submitted projections and review of other hospital rates, staff has determined that the statewide median rate and the Hospital's projected rates are as follows:

	Statewide Med. Rate	Projected Rate	Approved Rate
Labor & Delivery (DEL)	$75.19	$83.78	$75.19
Obstetrics (OBS)	965.49	1,049.24	965.49
Nursery (NUR)	631.91	707.86	631.91

Recommendation

After reviewing the Hospital's application, the staff has the following recommendations:

1. That COMAR 10.37.10.07 requiring that rate applications be made 60 days prior to the opening of a new service be waived;
2. That the DEL rate of $75.19 per RVU, OBS rate of $965.49 per patient day, and NUR rate of $631.91 per patient day be approved as the new rates effective July 1, 2009;
3. That no change be made to the Hospital's Charge per Case standard for DEL, OBS, and NUR

services; and

4. That the DEL, OBS, and NUR rates not be rate realigned until a full year's experience data have been reported to the Commission.

IN RE: THE APPLICATION FOR	*****	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*****	**SERVICES COST REVIEW**	
DETERMINATION	*****	**COMMISSION**	
UNIVERSITY OF MARYLAND	*****	**DOCKET:**	**2009**
MEDICAL CENTER	*****	**FOLIO:**	**1844**
BALTIMORE, MARYLAND	*****	**PROCEEDING:**	**2034A**

Staff Recommendation

August 5, 2009

I. INTRODUCTION

University of Maryland Medical Center ("Hospital") filed an application with the HSCRC on July 14, 2009 for an alternative method of rate determination pursuant to COMAR 10.37.10.06. The Hospital requests approval from the HSCRC for continued participation in global rates for solid organ transplant, gamma knife, and blood and bone marrow transplants for an additional year with Aetna Health, Inc. beginning August 1, 2009.

II. OVERVIEW OF APPLICATION

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

III. FEE DEVELOPMENT

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

IV. IDENTIFICATION AND ASSESSMENT OF RISK

The Hospital will continue to submit bills to UPI for all contracted and covered services. UPI is responsible for billing the payer, collecting payments, disbursing payments to the Hospital at its full HSCRC approved rates, and reimbursing the physicians. The Hospital contends that the arrangement between UPI and the Hospital holds the Hospital harmless from any shortfalls in payment from the global price contract.

V. STAFF EVALUATION

Staff reviewed the experience under this arrangement and found it to be favorable. Staff believes that the Hospital can continue to achieve favorable performance under this arrangement.

VI. STAFF RECOMMENDATION

Based on the Hospital's favorable performance, staff recommends that the Commission approve the Hospital's application for an alternative method of rate determination for solid organ transplant, gamma knife, and blood and bone marrow transplant services, for a one year period beginning August 1, 2009. The Hospital will need to file a renewal application to be considered for continued participation.

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

IN RE: THE PARTIAL RATE	*	**BEFORE THE HEALTH SERVICES**
APPLICATION OF	*	**COST REVIEW COMMISSION**
CARROLL HOSPITAL	*	**DOCKET: 2009**
CENTER	*	**FOLIO: 1845**
WESTMINSTER, MARYLAND	*	**PROCEEDING: 2035R**

*** ***

Staff Recommendation

August 5, 2009

Introduction

On July 24, 2009, Carroll Hospital Center (the Hospital) submitted a partial rate application to the Commission requesting a rate for Renal Dialysis (RDL) services to be provided in-house beginning on July 1, 2009. The Hospital currently has a rebundled rate for RDL services. The Hospital is requesting that the RDL rate be set at the statewide median with an effective date of July 1, 2009.

Staff Evaluation

The Hospital submitted its RDL costs and statistical projections for FY 2010 to the Commission in order to determine if the Hospital's RDL rate should be set at the statewide median rate or at a rate based on its cost experience. Based on this information, staff determined that the RDL rate based on the Hospital's projected data would be $882.62 per treatment, while the statewide median rate for RDL services is $637.71 per treatment.

Recommendation

After reviewing the Hospital's application, the staff has the following recommendations:

1. That COMAR 10.37.10.07 requiring that rate applications be made 60 days prior to the opening of a new service be waived;
2. That the RDL rate of $637.71 per treatment be approved effective August 1, 2009;
3. That no change be made to the Hospital's Charge per Case standard for RDL services; and
4. That the RDL rate not be rate realigned until a full year's experience data have been reported to the Commission.

Maryland
Hospital Association

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

July 28, 2009

Donald Young, M.D.
Chairman
Health Services Cost Review Commission
6109 Trotter Ridge Court
Columbia, MD 21044

Dear Dr. Young:

On August 5 you will be asked to approve the final list of potentially preventable complications (PPCs) to be included in the new Maryland Hospital-Acquired Conditions (MHAC) policy. The purpose of this letter is to share several concerns that have arisen during the clinical vetting process that we believe must be addressed as you consider this important action.

Dissemination of Evidence-Based Prevention Protocols

Over the past two months clinicians have been reviewing their case data and focusing on areas where it appears they have the greatest opportunity for improvement. During the vetting sessions, 3M representatives and Health Services Cost Review Commission (HSCRC) staff reiterated that if a hospital's actual complication rate for a given PPC was greater than the statewide risk-adjusted norm, this should signal further exploration. However, 3M has not shared the evidence-based research upon which their determinations are made or the prevention protocols that can be implemented to avoid these "highly preventable hospital-acquired conditions." More important, in some instances there are no clear prevention guidelines. It is inappropriate to have a statewide policy that penalizes hospitals without providing them with the information needed to improve their performance. **We recommend that 3M be required to release the known evidence-based practice protocols to prevent the occurrence of complications covered by the MHAC policy.**

Objective Third Party Review

Throughout the vetting process, Maryland Hospital Association (MHA) and hospital clinicians submitted recommended changes to the PPCs to HSCRC staff, who in turn referred these comments to 3M for review and response. Since 3M is the company that developed the PPC Grouper Software, the same clinicians who originally created the clinical assignment and exclusion logic of the PPCs were asked to both review and be the final arbiter of proposed changes to the PPC system.

By definition, in a vetting process reasonable clinicians may have different views and disagree, especially where there is a lack of clear evidence. **For this to be a valid process, the HSCRC must engage the services of an objective third party to consider the disparate views, balancing the proprietary interests of 3M with the views of other clinicians and making an independent determination of proposed modifications to the PPCs.**

- more -

Insufficient Time to Review All 52 PPCs

To aid in this process, MHA convened a PPC Clinical Advisory Work Group made up of clinicians across the state. In the brief time provided, they were able to review almost half of the PPCs covered under the proposed MHAC policy. At the same time, hospitals received data about hundreds to thousands of cases, and were only able to review a small sample of them. As indicated in previous comments by hospital leaders, these conditions and the 3M clinical logic are quite complex and it is a time-consuming and labor-intensive process to examine in detail each one. Consequently, approximately half of the PPCs have not been fully examined or discussed in the vetting process.

We appreciate the HSCRC staff's recognition of the need to continue to improve the PPC policy. The staff has agreed to form a clinical advisory group this fall "to support an ongoing process of receiving and responding to input that informs the refinement of the PPCs used as the basis of our payment adjustments for Maryland Hospital-Acquired Conditions." **We recommend that the work group be charged with continuing to perform an in-depth analysis of the PPCs, monitoring the impact on quality outcomes, and identifying issues that warrant immediate and/or longer term attention.**

Availability of Software and Reports

In June, the commission adopted a new payment policy for MHACs that is based on a 3M proprietary software tool. Just a few months earlier, the National Quality Forum, the national organization that is responsible for endorsing measures to be used for quality reporting and improvement, rejected the 3M PPC measures submitted for endorsement, in part because the PPC system is not publicly available and can only be accessed through purchase of a license. Since the state of Maryland is mandating use of a proprietary product to determine certain payment adjustments, as a public service **the 3M PPC Software Grouper should be made available to hospitals at no cost.** In addition, if arrangements are being made for another company to run the reports that hospitals need, these analyses should be provided to hospitals at no cost.

We appreciate the opportunity to submit these recommendations, and would be happy to provide more detailed information. I can be reached at 410-379-6200 or at bmiller@mhaonline.org.

Sincerely,

Beverly L. Miller
Senior Vice President, Professional Activities

cc: Robert Murray, HSCRC Executive Director

St. Mary's Hospital

Mr. Robert Murray, Executive Director
Ms. Diane Feeney, Associate Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

July 20, 2009

Dear Diane:

While we applaud the Health Services Cost Review Commission's initiative to support pay for performance goals and support the concept of ensuring that patient care in Maryland is safe, effective, and efficient, we are writing to share our concerns about the Commission's new Potentially Preventable Complication (PPC) payment methodology under consideration at this time.

We are taking this opportunity to write to you because the conference call wherein hospitals were encouraged to share concerns was without much substance and appeared to be only a formality. The physician's continued and repeated response that the statistical methodology and excellent coding would account for the clinical concerns voiced on the call is not acceptable to physicians in our region, including Medical Staff Officers, Chiefs of Departments, professors of Medicine and bedside practicing physicians.

Aside from the fact that there has been inadequate time to account for the unfunded and extensive process the hospitals had to undertake to review their case data, once reviews were underway, the data were determined to be incorrect, causing a second wave of unfunded reviews to begin. *A solution would be to slow down the process so hospitals can adequately analyze the data and its impact on care and so the clinical work group can continue to vet the PPC's and identify needed inclusion and exclusion criteria.*

We certainly understand the statistical value of severity adjusting the cases and using complex formulas to identify the expected rates for the proposed potentially preventable complications. We also support excellent and detailed coding. However, when physicians around the region are learning of the 52 PPC's, they are not comforted by the fact that there is a proprietary 3M formula to keep the data equitable. They are less comforted by the expectation that coders can ensure that PPC's are realistically identified. They are most concerned that the PPC's are not, in some cases based on

clinically sound judgment, and are not, in some cases, preventable. Their response to these concerns is to stop providing comprehensive care or in some cases any care, to patients. Thus we believe this system will lead to a very serious and unintended consequence for the sickest patients in Maryland, which is to limit care or direct care to physicians/hospitals willing to take more risk, regardless of their abilities. Several of many examples are listed below.

Upon review of the PPC's, physicians are saying it would be foolhardy to do any urine analyses for patients in Maryland hospitals because the HSCRC regards *all* urinary tract infections as PPC's. A case can be made for patients with catheter-related urinary tract infections having a hospital acquired complication, but for those who do not have this entry site for bacteria, there is little to explain the HSCRC's rationale except that statistics will manage the concern. To reiterate, clinicians are not comforted by complicated formulas taking care of the clinical concerns. They are saying they may not order any more urine testing for hospitalized patients.

Patients with poor wound healing, hypoglycemia and or hypertension post operatively are others who may suffer. Physicians may no longer perform surgery on diabetic patients or those with peripheral vascular disease based on the PPC list, and are considering pulling out of the ventilator bundle indicators, which call for patients on ventilators to have tight glycemic control since hypoglycemia is a PPC. The literature is replete with articles about the potential for hypoglycemia when attempting tight glycemic control. Glycemic control was already a controversial subject, with leanings towards loosening the control and re-analyzing which patients best benefit from the lower blood sugars. With the literature so contradictory at this time, why would the HSCRC choose hypoglycemia for surgical patients as a topic for a PPC?

Physicians are seeing some of these contradictory data points as further illustration of the lack of understanding of governmental agencies attempting to engineer care by unfunded mandate. This new initiative, combined with the lack of tort reform in Maryland is resulting in physicians stating that their answer is not to care for those complicated patients or to leave the state.

The MHA clinical task force worked with Navigant Consulting to create a list of inclusion and exclusion criteria that make the current list of potentially preventable complications more realistic, regardless of the statistics. *A solution to reduce the unintended consequence of limited care and/or directed care to physicians who are willing to take more risks would be to allow clinically sound exclusion criteria for each PPC* so we are not asking clinicians to solely trust proprietary formulas by statisticians who are not related to patients or familiar with the practice of medicine when determining whether or not he/she will provide care to patients in need. *The MHA taskforce can continue its work to completion.* (See attachment 1)

Lastly, there are no evidence- based guidelines for some of the PPC's. *We would suggest that there be evidence- based data supporting the preventability of each complication and best practice guidelines to avoid each PPC.* What would be the evidence-based practice

to prevent the PPC about cardiac dysrhythmias for patients who are having electrophysiology studies when the dysrhythmias are induced to identify the best treatments? This was discussed on the conference call wherein the physician was unaware that the dysrhythmias in this instance are indeed induced.

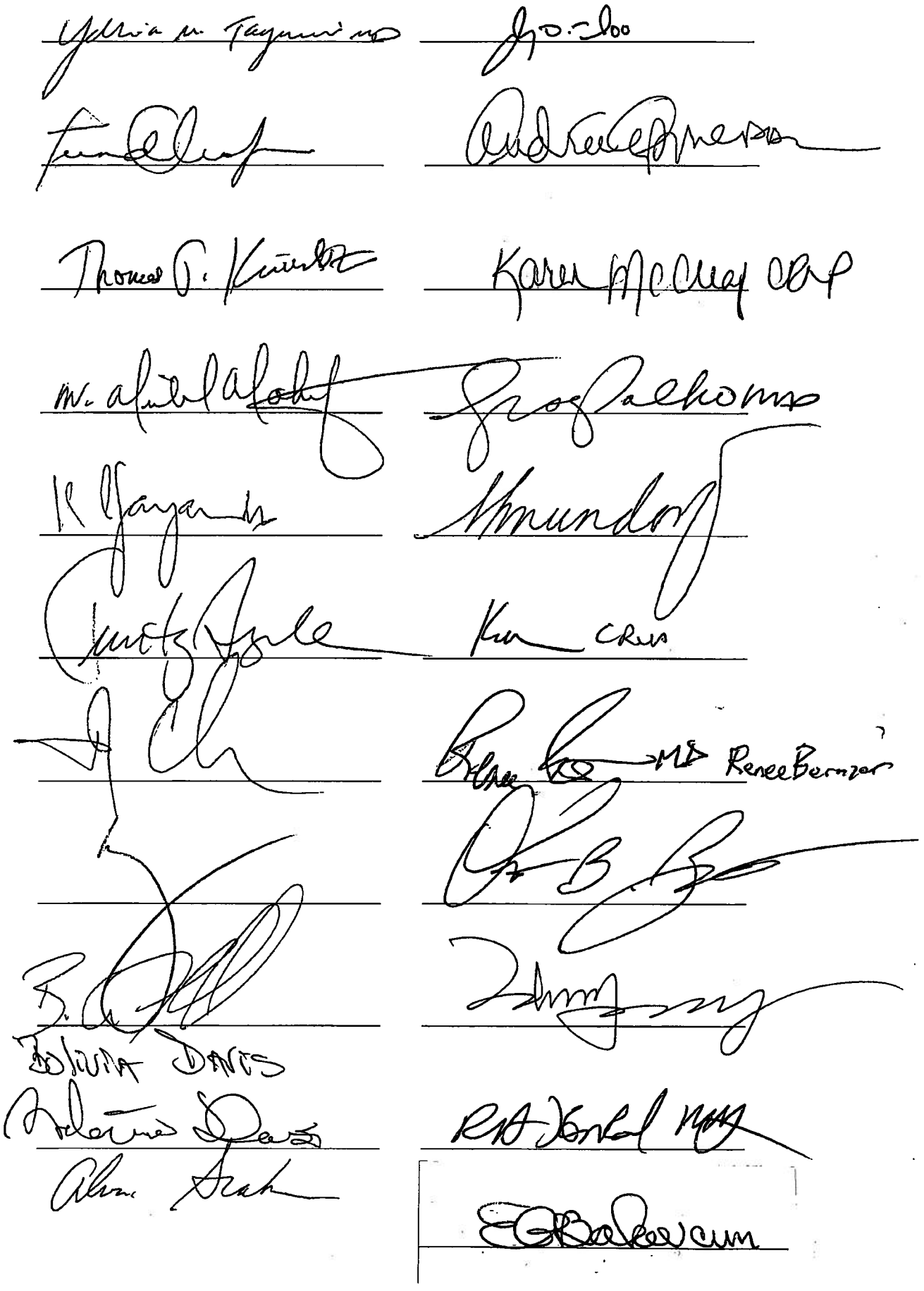
We believe the desire to move quickly is thwarting the opportunity to truly improve care. We believe the heavy reliance on coders and statistical analyses to compensate for suboptimal clinical analysis will lead to unintended consequences wherein care will be withheld, poorly documented, or directed to physicians and hospitals willing to take more risk than others, regardless of their clinical ability.

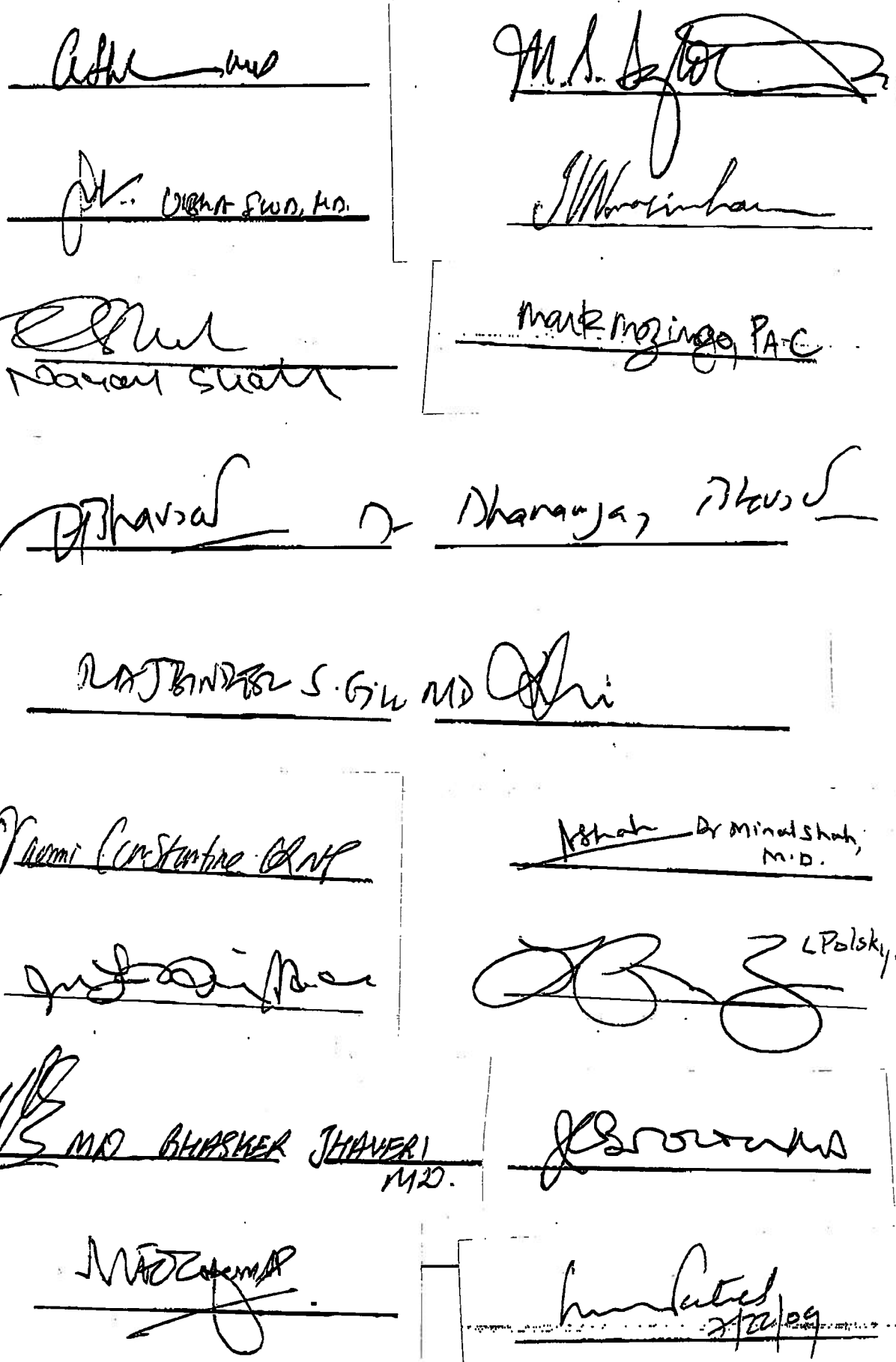
Please consider taking the time to allow more complete analysis of the data. Please consider making the recommended changes to the inclusion and exclusion criteria. Please use a think-tank approach to ensure that all PPC's have documented best practice strategies for real prevention.

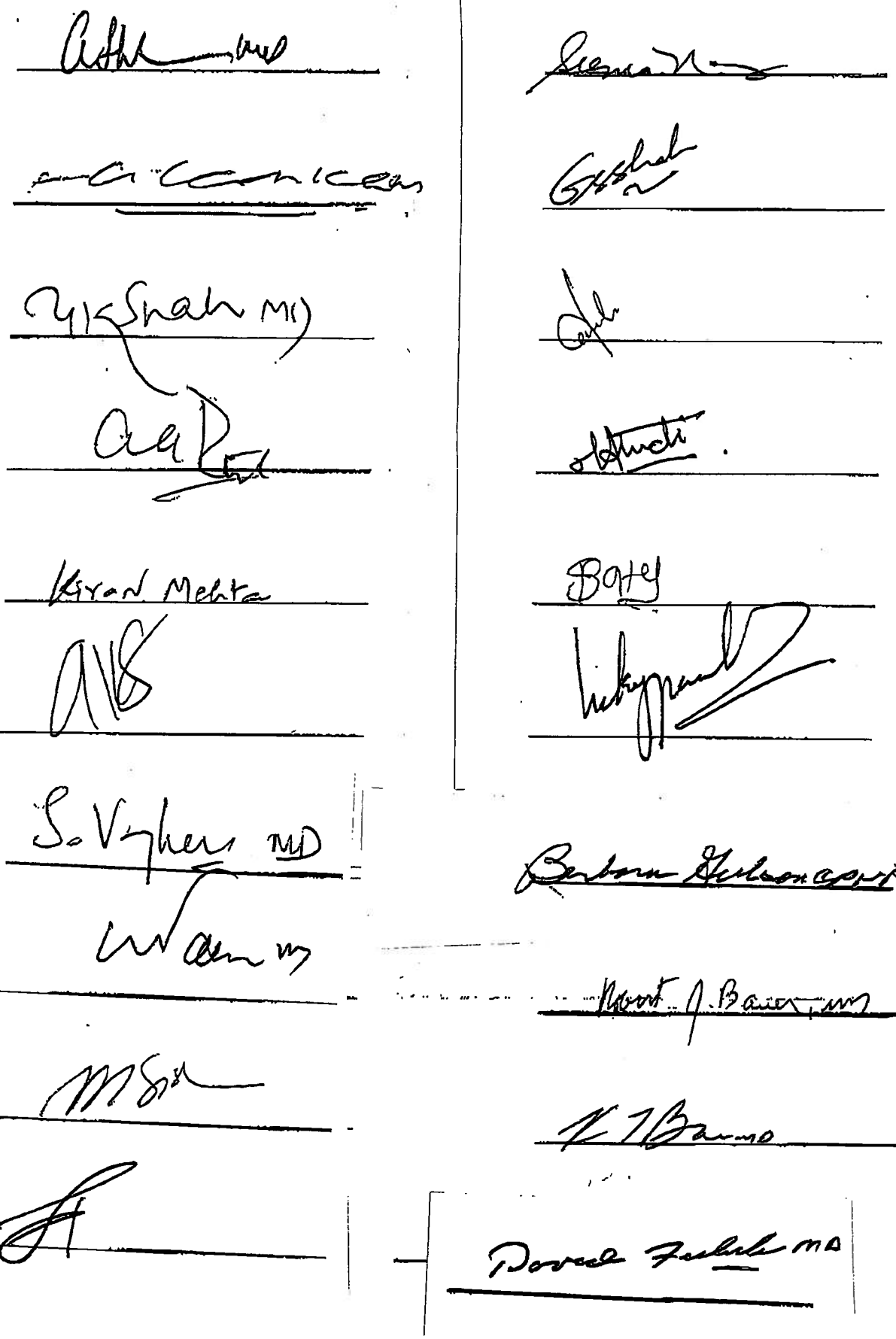
Thank you for your consideration of these requests.

Sincerely,

Attachments
Cc: Bev Miller, Vice President
Maryland Hospital Association







MD

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(Atul R. Shah, MD)

MD

ATMunshi · M.D.
(ANWAR MUNSHI)

MedChi
The Maryland State Medical Society

1211 Cathedral Street
Baltimore, MD 21201-5516
410.539.0872
Fax: 410.547.0915

1.800.492.1056

www.medchi.org

July 31, 2009

Robert Murray
Executive Director

Dianne Feeney
Associate Director, Quality Initiative
Health Services Cost Review Commission
4160 Patterson Ave
Baltimore, MD 21215

RE: Maryland Hospital Acquired Conditions Policy

Dear Mr. Murray and Ms. Feeney:

On behalf of the members of MedChi, The Maryland State Medical Society, I wanted to take the opportunity to communicate some general comments and concerns that the physician community has regarding the Hospital Acquired Conditions Policy (MHAC) that will be considered for adoption at the Commission's August meeting. MedChi is aware of the significant work that has been done to bring this new ground-breaking program to its present configuration. MedChi is very supportive of the goals and objectives of the program and the comments incorporated in this letter are not intended to take away from MedChi's overall support for this initiative. However, our members felt compelled to express their concern over certain aspects of the program's development that they believe could jeopardize the long term success of the initiative. It is within that context that I express the following concerns/recommendations:

Number of PPCs: The number of potentially preventable conditions (PPCs) that will be incorporated into the initial implementation of the program has been expanded from 11 to 52. While Med Chi understands that the increased number of PPCs is related to the fact that the program will now be rate based and will not penalize hospitals for individual cases, it nonetheless is a significant number of PPCs to effectively incorporate into a program that is the first of its kind in the nation and for which there is no existing data/experience to help identify potential implementation difficulties. It's is Med Chi's belief that if too many PPCs are implemented initially, the administrative and system complexity of concurrently addressing so many clinical issues simultaneously may jeopardize the long term success of the program. This initiative clearly provided long term potential for system savings. That potential for system reform and savings should not be placed in jeopardy by rushing to implement such a large number of PPCs at the outset.

Objective Third Party Involvement in the Vetting Process: The Commission established a clinical "vetting" process intended to refine the PPCs to be included in this initiative. A significant number of clinicians have participated in these sessions however the structure of the "vetting process" has not fostered the collaborative dialogue that was intended nor resulted in consensus decisions on the parameters of the inclusions and exclusions of the PPCs under consideration. The PPCs by their very definition spark significant debate on the appropriate inclusions and exclusions. While the clinicians have raised various issues with the PPCs and have made significant and detailed recommendations for

modifications of some of those PPCs, the 3M consultants who developed the PPC model hold the authority to accept or reject the various recommendations. Many of the recommendations have been summarily dismissed by 3M without providing the clinical evidence upon which the 3M consultants made their decision. 3M and its consultants are to be applauded for the product they have produced and their vision for quality enhancement and cost containment. However, because 3M developed the PPC model, Med Chi believes that they should not also be the entity that makes the final decision on the scope of the PPCs. This is not a criticism of 3M and its consultants. In almost any circumstance one could imagine, an entity that develops a product/program has a bias in favor of its program that makes it exceedingly difficult for that entity to be objective regarding suggested modifications. The Commission should have an independent clinical entity that evaluates clinicians' suggested modifications to the PPCs and 3M's response to those suggestions. That independent clinical entity, and not 3M, should make the final determination on the scope of each PPC.

Ongoing Process: MedChi would strongly urge the Commission to establish a permanent Advisory Committee to continue to work with the Commission and 3M on the clinical "vetting" of the PPCs and the implementation of the MHAC. MedChi would further urge the Commission to narrow the number of PPCs that are initially implemented and to add PPCs to the program only once they are fully "vetted" by the Advisory Committee. MedChi appreciates that Commission has made significant changes in the structure of the program and believe that its careful and thoughtful implementation will in fact yield both quality enhancement and cost savings. However, the administrative complexity of implementation, both for the Commission and the hospitals, coupled with the fact that this is program has not been implemented anywhere in the country, calls for cautious, thoughtful, and pragmatic implementation. Starting with fewer PPCs "vetted" to a point of consensus amongst clinicians seems a prudent structure for implementation. It is easier to expand and enhance a successful program that is modest in its initial implementation than to resurrect an aggressive program that crumbled due to its initial complexity.

Thank you in advance for the Commission's consideration of MedChi's concerns. MedChi and its members look forward to continuing to work with the Commission as they finalize the parameters of the program and its implementation framework. The MHAC policy holds great promise and we are pleased to be at the table.

Sincerely,

Ronald C. Sroka, MD

Ronald C. Sroka, M.D.
President
MedChi, The Maryland State Medical Society

Cc: Members of the Health Services Cost Review Commission
The Honorable John Colmers, Secretary, DHMH
The Honorable Michael Busch
The Honorable Joan Carter Conway
The Honorable Ulysses Currie

The Honorable Mary Dulany-James
The Honorable Rob Garagiola
The Honorable Edward J. Kasemeyer
The Honorable Thomas Middleton
The Honorable Warren E. Miller
The Honorable Peter Hammen
The Honorable Shane Pendergrass

WASHINGTON COUNTY HOSPITAL

T. Michael White, MD, FACP
Chief Medical Officer
Washington County Hospital
251 East Antietam Street
Hagerstown, MD 21740

Phone: 301-790-8755
Fax: 301-790-9231
E-Mail: mwhite@wchsys.org

August 04, 2009

Mr. Robert Murray, Executive Director
Ms. Diane Feeney, Associate Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Ms. Feeney and Mr. Murray:

The purpose of this letter is to share my healthcare value (compassionate care; quality outcomes; patient safety; customer satisfaction; patient advocacy/resource utilization) perspective on the Maryland Hospital Acquired Conditions/Potentially Preventable Conditions (MD HAC/PPC) debate.

I wish to commend the HSCRC's commitment to partnering to advance safe, efficient, effective, timely, just/equitable patient-centered care as Maryland aspires to become the safest state for patient care in the country. I recognize our hospital to be in full partnership with your efforts.

The **context for my remarks** is as follows:

- Hospitals are complex and chaordic (functioning somewhere between chaos and organized).
- Hospitals are unsafe (truth may be painful; but, it is the shortest distance between two points).
- Patients are becoming increasingly complex and vulnerable.
- Resources are increasingly diminishing.
- Hospitals are the final common denominator to resolve these irresolvable issues.

Within this context, I wish to make **three points**:

1. After review, a blunt tool (a huge, complex, poorly negotiated unfunded mandate MD HSC/PPC emanating from methodology that no one has confidence) is not what is required to assist already struggling hospitals to meet their privilege and responsibility to serve their increasingly complex and vulnerable communities. As with any blunt tool, there is **too much peril for harm through unintended consequences**.

   Note: This mandate is unfunded in three ways:

   - It threatens to take resources away from hospitals' critical bottom lines;
   - It requires huge unfunded resources to understand and react to MD HSC/PPC;

- It distracts Care/Quality/Patient Safety/Risk Management professionals from their already well-prioritized, overabundant tasks at hand: thereby threatening extant quality/patient safety efforts.

2. An understanding of clinical complexity and sound complex decision-making may assist with an understanding of how **well- intentioned incentives for improvement may actually cause harm:**

- ***C. difficile*** has morphed to a highly virulent, epidemic scourge. Enlightened hospitals are identifying it as often and as early as possible to: isolate patients to prevent spread to other patients and staff; to start therapy ASAP to prevent the life-altering consequences of colectomy and colostomy; and, prevent mortality from this aggressive organism. Note: hospitals "doing it right", may have a higher prevalence. Note: there is no connection between the disease and cause by the hospital. Note: any disincentive to aggressive early recognition **(the more the better)** may have severe unintended consequences. Note: I would advocate the statewide tracking of *C. difficile* associated colectomies and deaths.
- A patient who has elective **hip replacement surgery** often is judged to require a perioperative Foley catheter to protect the wound from infection. The Foley must be removed ASAP. Upon removal of the catheter, the urine may grow an organism and must be sterilized to avoid the devastating consequence of an infected hip prosthesis. Any incentive to alter this thoughtful process may lead to the devastating consequence of an infected hip prosthesis.
- The number one safety issue in hospitals is patient falls. The number one cause of falls is confusion. Because of their admitting condition, patients who come into the hospital often become confused. Therefore, we must identify **"acute mental health changes"** as early and as often as possible: to diagnose and treat the cause of confusion (acute delirium is a potentially life-threatening condition); and, to keep the patient safe from falls. Note: hospitals "doing it right", may have a higher prevalence. Note: there is no connection between the disease and cause by the hospital. Note: any disincentive to aggressive early recognition **(the more the better)** may have severe unintended consequences.

3. After review, I am not confident that the HSCRC is adequately oriented to the Administration, Board, Medical Staff, Nursing, and Department Head processes that are in play each day at each hospital:

- Prevention processes (e.g. perinatal collaborative);
- Reporting of incidents and near misses;
- Root Cause Analysis;
- Action Plans/Responsible Parties (Champions);
- Accountability/Peer Review processes;
- Medical Executive Committee; Board Quality Committee; and, Board oversight.

I have great fear that the MD HAC/PPC proposal will, **as a most severe unintended consequence, distract, disrupt and divert scarce hospital resources from these quality/patient safety processes.**

In closing, I respectfully make the following recommendation for consideration by the HSCRC:

1. Hospitals need to be safer.
2. HSCRC should partner towards this end.
3. The logical partners are the HSCRC, the hospitals, MHA, and the MPSC.
4. The 3M information should identify a finite (e.g., five) number of PPCs to be eliminated in Maryland.
5. Five collaboratives (Hospitals, HSCRC, MHA, and MPSC) should be funded.
6. Hospitals participating and demonstrating gains will benefit from lower costs (as will HSCRC).
7. Strategies will be needed to address non-performing hospitals (a complex conversation for another day).
8. Over time, (perhaps one year hence) 3M data may again assist with finding another finite group (e.g., two) of PPCs to add to the collaboratives.

Central to this suggestion: the hospitals are being assisted with identification of logical opportunities and centralized efficient, effective solutions (collaboratives) --- bolstering precious hospital quality/patient safety resources to logically implement and continuously improve collaborative processes at the bedside.

In summary, I am advocating a statewide partnership to bolster quality outcomes and patient safety; and, at the same time, I am advocating against the MD HAC/PPC it has the unintended consequence, of distracting, disrupting and diverting already scarce hospital resources from quality/patient safety processes.

Again, I wish to commend the HSCRC's commitment to partnering to advance safe, efficient, effective, timely, just/equitable patient-centered care as Maryland aspires to become the safest state for patient care in the country. Again, our hospital is in full partnership with you. Thank you for this opportunity to provide input into this important process.

Respectfully submitted,

T. Michael White, MD, FACP
Chief Medical Officer

Staff Draft Recommendation for an Alternative Method of Financing Board of Public Works Approved Medicaid Day Limits

August 5, 2009

This represents a draft recommendation of the HSCRC. Any comments regarding this draft recommendation should be submitted to Robert Murray, HSCRC Executive Director, on or before August 21, 2009.

Draft Recommendation for an Alternative Method of Financing Board of Public Works Approved Medicaid Day Limits

Introduction

This recommendation follows action approved by the Maryland Public Works (BPW) at its July 2009 meeting to achieve budget reductions through re-imposition of Medicaid day limits (MDLs) effective January 1, 2010. In lieu of MDLs, BPW expressly allowed for an HSCRC alternative approach that would generate approximately $24.2 million in State savings during FY 2010. This recommendation proposes that alternative approach.

Background on Medicaid Day Limits

In past years, during times of severe State budgetary shortfalls, the Department of Health and Mental Hygiene (DHMH) has proposed stop-gap payment reductions as a means of assisting the State in balancing its budget. In fiscal 2004, budget constraints led DHMH to implement hospital day limits for Medicaid enrollees. MDLs cap the number of days that Medicaid will pay for a hospital stay at a percentage of the average length of stay (ALOS) by diagnosis-related group (DRG). A hospital is not paid by Medicaid for additional days beyond this limit.

In December 2003, DHMH proposed regulations to implement MDLs at 95% of ALOS. In response to revised savings estimates and comments on the proposed regulations, DHMH loosened the day limits to 105% of ALOS and specified that the day limits would expire on June 30, 2005. Over this 18 month period, MDLs were expected to reduce State Medicaid expenditures by $30 million. This would also mean that the State would forgo $30 million in federal matching funds.

Under standard HSCRC policy at the time, any uncompensated care (UC) associated with the MDLs would be recognized through the uncompensated care regression over a three year period. Given the scale of the proposed day limits and concerns regarding hospital profitability, the HSCRC in December 2003 amended its uncompensated care policy to allow 80 percent of the uncompensated care costs to be reimbursed up front, with the remaining 20 percent funded in accordance with regular UC policy. The Commission, by regulation, also permitted hospitals with financial need to seek additional relief through the partial rate application process. These actions mitigated the impact of day limits on hospitals, particularly those hospitals with high proportions of Medicaid patients. Five hospitals were granted relief under these regulations.

Though initially intended to terminate after 18 months, continued budgetary pressures in fiscal 2005 led DHMH to extend MDLs through June 30, 2006, and also to tighten the limits from 105% to 100% of ALOS. In response, the 2005 *Joint Chairmen's Report* stated it was the intent of the budget committees that fiscal 2006 be the final year of hospital day limits as a cost-containment measure. Day limits were loosened from 100% to 105 % of ALOS for the last half of fiscal 2006, but funding to discontinue day limits was not included in the fiscal 2007 budget. Therefore, in June 2006, DHMH submitted regulations to extend day limits through June 30,

2007 – a full two years beyond the termination date included in the original regulations – and to further relax the day limits from 105% to 120% percent of ALOS.

During the 2006 Interim, the HSCRC was subject to a Sunset Evaluation conducted by the Department of Legislative Services (DLS). After an in-depth review of the MDL policy, DLS found that, "although Medicaid day limits achieve cost savings to the general fund budget, they increase health care costs in the State and are detrimental to the all-payer system." Therefore, DLS recommended that MDLs not be extended beyond the June 30, 2007 termination date, and that DHMH should work with the Department of Budget and Management to identify alternative savings in the FY 2008 budget. Nonetheless, action taken by the budget conference committees in 2007 extended day limits into FY 2008.

During the 2008 Legislative Session, House Bill 1587 (Chapter 245) was enacted to initiate a uniform, broad-based, and reasonable assessment on hospital rates to reflect the reduction in hospital uncompensated care realized from the expansion of Medicaid eligibility to parents, caretakers, and childless adults with income between 46% and 116% of the federal poverty guidelines. This legislation also discontinued the use of MDLs effective July 1, 2008 and replaced it with a uniform assessment of $19 million to be transferred to the Medical Assistance Program in lieu of 6 months of day limits in FY 2009.

Difficulties Associated with Imposition of Day Limits and HSCRC Response

Each year, the Commission has found that the actual impact of MDLs was greater than the anticipated impact. Therefore, MDLs have shown to be a highly inaccurate method to address DHMH fiscal issues. As illustrated above, the MDLs in a given fiscal year are based on estimates of the average length of stay and utilization by DRG. The HSCRC has worked with the Medicaid program to determine the actual experience. This process has been extremely complicated and difficult to administer. It takes several years before the actual impact can be quantified, and further adjustments are then required to the uncompensated care provision in rates. Also, the re-imposition of day limits raises the specter of day limits becoming an embedded element of the rate system. The State initially designated MDLs as an interim 18 month stop-gap measure. As such, the HSCRC hesitantly agreed to facilitate their imposition by largely indemnifying hospitals through prospective rate action. Despite the Commission's continued efforts over the years to eliminate MDLs, legislators have continued to propose and enact them to varying degrees. Experience has shown that day limits, once implemented, are very difficult to remove as a budget cutting strategy. Further, when the policy of the Commission is to ensure that hospitals are not impacted on a cash-flow basis by back-filling impacts on uncompensated care, those not adversely affected by the policy (i.e., hospitals) have little incentive to mount significant opposition. On the other hand, those parties most harmed by the imposition of day limits (i.e., Medicare and first party payers) have not exerted sufficient political force to prevent their imposition or effectuate their elimination.

The Centers for Medicare and Medicaid Services (CMS) has indicated to HSCRC staff their opposition to MDLs citing inherent equity issues. Given that one of the two federal tests to retain the Medicare waiver is that it must remain all-payer, Staff remains very concerned about

the serious equity implications associated with any re-imposition of day limits and associated HSCRC rate action.

HSCRC Response: Alternative Method for Financing Approved BPW Action

The staff considered an alternative method for financing amounts earmarked for budget reductions to the Medicaid program. As noted above, the last vestige of day limit funding was accomplished in 2009 through the imposition of a small but broad-based and uniform assessment on all hospital rates, which applied to all payers equally. These amounts were then collected by hospitals and transferred to the Medicaid program, along with estimated amounts associated with averted hospital uncompensated care resulting from Medicaid expansion.

DHMH has agreed to this alternative way of implementing BPW action through the imposition of a broad-based and uniform assessment to generate an additional $8.9 million in State General Fund savings for Medicaid between Jan 1, 2010 and June 30, 2010 in lieu of day limits. This approach is inherently a far more equitable way to address the State budgetary problems. This approach is also much preferred to MDLs due to the following factors:

- No significant administrative issues;

- The amount of actual savings is known up front rather than waiting several years to obtain data to verify savings and make relevant adjustments to uncompensated care;

- The alternative is broad-based and uniform, payment implications apply to all payers proportionally, and, from a payment standpoint, no payer is advantaged or disadvantaged; and

- This alternative accomplishes the same budgetary result as MDLs without the HSCRC having to administratively react to regulations issued by DHMH.

Staff Recommendation

1. The imposition of a one-year, broad-based, and uniform hospital assessment in FY 2010 in the amount of $8,897,720, conducted in the same manner as the $19 million assessment that was imposed in FY 2009, in lieu of Medicaid day limits;

2. Instruct hospitals to remit their calculated proportion of the assessment to Medicaid beginning January 1, 2010; and

3. The assessment will terminate June 30, 2010.

Final Staff Recommendation on Seed Funding for Development of a Statewide Health Information Exchange in Maryland

August 5, 2009

This represents a final recommendation of the Maryland Health Care Commission and HSCRC Staff

Final Staff Recommendation on Seed Funding for the Development of a Statewide Health Information Exchange in Maryland

Introduction

This final recommendation proposes permitting seed funding of up to $10 million through hospital rates over the next 2-5 years to support the development of a statewide health information exchange in Maryland.

HIE Strategy

Health information technology can help improve health care quality, prevent medical errors, and reduce health care costs by providing essential information at the time and place of care delivery. There are two principle tasks required to achieve a more efficient and effective health care delivery system: assuring that the relevant clinical data (and decision support) are available at the time and place of care, and assuring that the information developed in the course of real-world treatment contributes to a provider's knowledge and shapes further practice.

Health information exchange (HIE) promises to transform the current health care system by ensuring that consumers have access to the highest quality, most efficient, and safest care by giving providers access to the right information at the right time. Building a successful HIE requires considerable planning in order to implement a business model that creates incentives for use, and recognizes the need for funding from those stakeholders that derive value and benefits for using technology to access and share electronic health information. A statewide HIE will create an interconnected, consumer-driven electronic health care system that enhances health care quality, safety, and effectiveness, and reduces health care costs.

The MHCC and the HSCRC implemented a two-phased approach to establishing a statewide HIE that consisted first of two different but parallel planning projects, followed by a single implementation project to build a statewide HIE. The purpose of the planning phase was to identify the best ideas submitted from the two multi-stakeholder groups working independently that could be merged into a single Request for Application (RFA) to build a statewide HIE that securely exchanges patient information across multiple provider settings. The nine month planning phase concluded in February 2009 and MHCC issued the RFA to build a statewide HIE in April.

The RFA Review Process

The MHCC and HSCRC convened a responder conference at the end of April to address specific vendor questions pertaining to the RFA. In June, staff received responses to the implementation RFA from CRISP (Chesapeake Regional Health Information System for our Patients), Deloitte, The Free State Joint Venture, and MEDNET. An evaluation committee consisting of representatives from the MHCC, HSCRC, and Health Care Information Consultants, LLC was convened to evaluate the responses to the RFA. The RFA contained the evaluation criteria along with the guidance for each section in developing an acceptable response. The evaluation committee concluded that CRISP and Deloitte were the only responders that met the requirements specified in the RFA. The review panel considered the submissions from the remaining two responders as insufficient and disqualified their proposals.

Key Assessment Categories

Organizational Infrastructure. CRISP plans to establish a Board of Advisors with broad responsibility for ensuring that the interests and perspectives of all stakeholders are included in the exchange, and plans to incorporate two representatives from the legislature to their governance. Deloitte proposes to include17 stakeholders to create a diverse representation in the governing body and assign each to one of three standing committees: clinical advisory, consumer advisory, and project management. CRISP included support letters from 24 stakeholder groups, while Deloitte included 3 in their response. CRISP proposes to outsource many of the organizational functions until the volume of work and revenue supports hiring staff. Deloitte plans to recruit for eight positions to support the infrastructure of the organization. ***The evaluation committee gave preference to the organizational infrastructure design of the CRISP proposal.***

Privacy and Security. CRISP and Deloitte indicated a commitment to work with the MHCC Policy Board to develop specific policies related to privacy and security.[1] CRISP plans to use the policy identified during the HIE planning phase as a framework for developing more robust policies. Deloitte plans to use HIPAA, the Maryland Confidentiality of Medical Records Act, and the Medicare Electronic Prescribing Rule as basic policies for the HIE. CRISP and Deloitte cited similar auditing functions for the HIE, where centralized auditing is a key feature. Provider access to the exchange is role-based in both designs. CRISP plans to authenticate users through a username and strong password that meets the requirements of the National Institute of Standards and Technology for authentication. Deloitte plans to implement a username and password for entry to the exchange and was not specific in their password design. CRISP proposes to use government issued identification at the point of care for authenticating consumers. Deloitte plans to implement identity proofing through an external identity provider, custom web-based application, or a web portal. ***The evaluation committee gave preference to the privacy and security approach in the CRISP proposal.***

Fundamental Design and Technical Architecture. CRISP and Deloitte proposed a decentralized hybrid infrastructure with a record locator service and master patient index. CRISP plans to identify technology partners through a competitive process where the Commissions would have veto authority over the selection. Deloitte identified *Medicity* as the technology partner in their response and plans to use a service-oriented architecture and incrementally deploy design features of the exchange. CRISP proposes to use the Healthcare Information Technology Standards Panel's *Continuity of Care Document C32*, which contains about 17 identifiable modules for storing patient specific information. The technology partner chosen by Deloitte complies with all *Integrating the Healthcare Enterprise* technical framework standards, and Deloitte plans to identify the use of appropriate profiles with the governing body. CRISP proposes to give consumers access to their health information through health record banks. Deloitte proposes to support third party personal health record applications. ***The evaluation committee gave preference to the fundamental design and technical architecture of the CRISP proposal.***

Exchange Functionality. CRISP proposed specific Use Cases grouped into categories based upon clinical value, the ease of implementation, and financial sustainability. Deloitte plans to base the Use Case selection on stakeholder value, technical challenge, implementation timeframe, and ROI, and would involve stakeholders in the selection process. CRISP proposes a staggered implementation of the Use Cases based on the sustainability of the HIE. Initially, CRISP plans to implement medication, labs, and discharge summaries. CRISP proposes to select additional Use Cases to pursue, with the guidance of the

[1] MHCC plans to identify members of the Policy Board in August.

exchange Board of Advisors and the Policy Board. Deloitte proposes to develop a detailed Use Case implementation strategy upon receipt of the award. ***The evaluation committee gave preference to the exchange functionality of the CRISP proposal***.

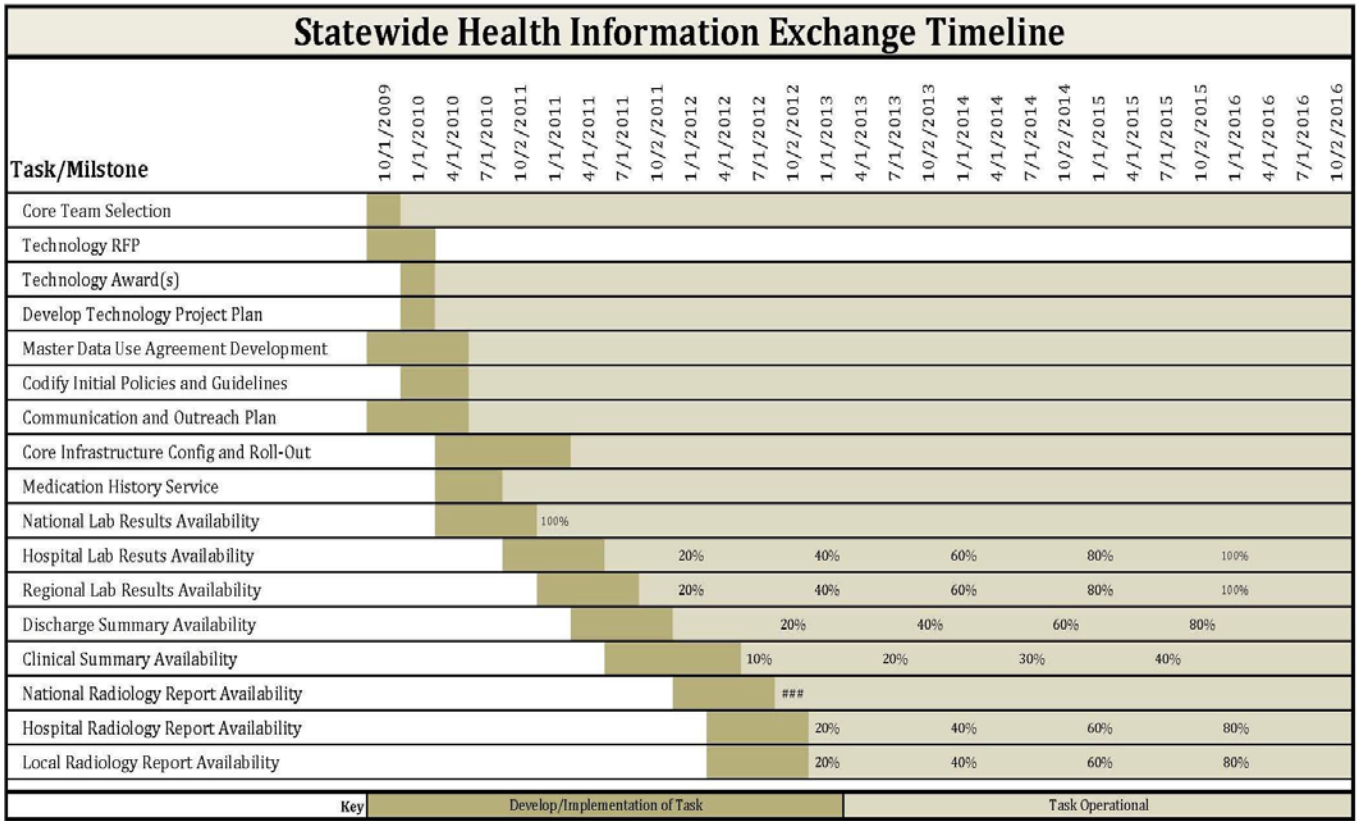
Response Comparison Table

A Consumer-Centric Health Information Exchange for Maryland *Leading Attributes*		
Categories	**CRISP**	**Deloitte**
Financial Model and Sustainability		
Revenue Sources	$10 million state funds, participating provider subscription fees, with potential to secure additional investments	$10M state funds, provider and payer transaction, subscription, or membership fees, Medicaid participation
Budget	**Year: 1. ($4.8M); 2. ($3.6M); 3. ($1.8M); 4. ($343K); 5. $730K**	**Year: 1. ($3.8M); 2. ($3.4M); 3. $11.6M; 4. $27.9M; 5. $49.3M**
Organization Infrastructure		
Ownership Model	Non-stock corporation, 9 Board of Directors, will seek 501(c)(3)	Will seek not-for-profit 501(c)(3)
Policy Board	Yes - convened by MHCC	Yes - convened by MHCC
Governance Composition	21 from RFA, suggest including 1 House and 1 Senate. Board of Advisors that will organize into 3 Committees: 1) Exchange Technology; 2) Clinical/Use Cases; and 3) Finance/Community	Board of Directors with Chair and 17 members, 3 Committees: 1) Clinical Advisory Committee; 2) Consumer Advisory Committee; and 3) Project Management Committee
Operational Structure	President, Clinical Assessment, Program Management Office, Provider/Patient Outreach Coordinator, Technical Operations, and Support Functions	Executive Director, Finance Manager, Technical Project Manager, Education and Outreach Manager, POC, Data Analyst, Administrative Assistant
Privacy and Security		
Access	Provider: Role-based access; Consumer: HRBs and PHRs	Provider: Access Control List; Consumer: PHRs (gateway)
Audit	Provider: Centralized auditing; Consumer: none	Provider: Centralized auditing; Consumer: none
Authentication	Provider: Username and strong password; Consumer: ID	Provider: username and password; Consumer: none
Authorization	Provider: Role; Consumer: controls flow of information	Provider: Role-based access; Consumer: MPI
Outreach and Education		
Consumers	Consumer groups; materials in various languages/educational levels; define message; tailor message; engage providers; media	Grassroots - provider to patient, Community Advisory Committee
Providers	Medical trading area study (MTA), Provider Outreach Coordinators (POC), deploy physician feedback mechanism	POC solicit agreements from providers, provide training, follow-up, and monitoring of HIE use.
Fundamental Design		
Data	Master Patient Index (MPI), edge servers	MPI. SOA, edge servers, data pointers
Request for Data	No info on opt-outs	No info on opt-outs
Exchange of Data	CCD C32: meds, allergies, PMH, labs, and D/C & clinical summaries	Real-time HL7 for clinical data
Publishing Data	Results delivery	Web-based and direct TCP/IP, results delivered to "inbox"
Technical Architecture		
Infrastructure	Decentralized hybrid infrastructure, MPI, and data registry	Decentralized hybrid, RLS, edge server.
SOA	Yes	Yes
Interstate HIE	Focus on statewide HIE and then national connections	NHIN standards for inter-HIE exchange of data
Underserved	Many advocacy groups engaged	Not defined
Interoperability	HITSP endorsed IHE standards for interoperability	Platform routes results into EMR, integrates order entry
PHR	PHR vendor interface	PHR vendor interface
EHR	Provider portal solution to access information	Web portal
Exchange Functionality		
Use Cases	Grouped (Chronological - A, B, C)	RFA Criteria for Use Case Selection, no defined plan
HIE Services	In chronological order - **Group A:** 1. Med Hx -> ED, 2. Lab Results; **Group B:** 1. Hospital Discharge Summaries (HDS) to ED, 2. HDS to Physicians/Clinics; **Group C:** 1. Chart Summary (CS) to ED, 2. CS to Physicians/Clinics, 3. Radiology Reports Delivery.	Utilize RFA Criteria and Standard Project Management Institute basics to determine Use Cases
Initial Use Cases	Final Use Case of Group A will be operational in late 2010	Outlined RFA Use Cases and timeline
Analytics/Reporting		
Analytics/Reports	Public Health, Care Management, Quality Improvement	Chronic Care, Utilization/Costs, Public Health

Staff Recommendations

CRISP proposes a technical approach for a statewide HIE that is flexible and includes policy that is protective yet not prohibitively restrictive, along with a financial approach that is sustainable. The statewide HIE will be a valuable resource to improve quality, increase safety, and ultimately decrease the cost of health care in Maryland. The Maryland Health Care Commission approved the CRISP approach on July16, 2009. ***Therefore, the Maryland Health Care Commission and HSCRC staff recommend that the HSCRC approve funding for CRISP to initiate the development of a statewide HIE through an adjustment to the rates of participating hospitals of up to $10 million over the next 2-5 years. MHCC and HSCRC staff will continue to review spending and funding needs and will make adjustments to annual funding as necessary. The HSCRC reserves the right to withhold or discontinue funding in the event that deliverables or expectations are not met.***

CRISP Proposed Implementation Plan



Staff Recommendation

August 5, 2009

Staff is concerned that in a case where an admission has been denied for medical necessity, it would still flow through the Charge-per-Case (CPC) methodology and inappropriately result in a hospital's maintaining revenue capacity.

Staff recommends that the Accounting and Budget Manual be amended to require a new quarterly report of Admissions Denied for Medical Necessity. The due date for this report is the same date the Quarterly Inpatient Discharge Abstract tape is due.

Admissions Denied for Medical Necessity

Hospital Name _____ Quarter Ended _____

Hospital Number _____

(1)	(2)	(3)
Medical Record Number	Admit Date	Total Charges Billed

(1)

Medical Record Number.

Enter on this line the unique medical record number assigned by the hospital for the patient's medical record.

The unique medical record number is to be assigned permanently to the patient and may not change regardless of the number of admissions for that particular patient during the patient's lifetime.

(2)

Admission Date

Enter on this line the month, day, and year of the patient's admission to the hospital. For example, April 4, 1992, is entered as 04041992 (mm/dd/yyyy).

(3)

Total Charges Billed

The full charges for all services provided to the patient shall be reported. These charges do not include Part B physician charges or charges not regulated by the Health Services Cost Review Commission (for example, telephone service, television charges, or private duty nursing charges).

Save file name as admdeny00##_qeyy.xls where 00xx is the hospital number; qe is quarter ending month; and yy is the calendar year.

TO: **Commissioners**

FROM: **Legal Department**

DATE: **July 31, 2009**

SUBJECT: **Hearing and Meeting Schedule**

Public Session

September 2, 2009	**Time to be determined, 4160 Patterson Avenue, HSCRC Conference Room**
October 14, 2009	**Time to be determined, 4160 Patterson Avenue, HSCRC Conference Room**

Please note, Commissioner packets will be available in Commission offices at 8:00 a.m.

The agenda for the Executive and Public Sessions will be available for your review on the Commission's Web Site, on the Monday before the Commission Meeting. To review the agenda, visit the Commission's web site at http://www.hscrc.state.md.us