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Vice Chairman

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Trudy R. Hall, M.D.

Steven B. Larsen, J.D.

C. James Lowthers

Herbert S. Wong, Ph.D.

STATE OF MARYLAND

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Deputy Director
Hospital Rate Setting

Charlotte Thompson
Deputy Director
Research and Methodology

Approved Documents

from the Public Session of the

463rd MEETING OF THE HEALTH SERVICES COST REVIEW COMMISSION
December 9, 2009

1. **Review of the Public Minutes of November 4, 2009**
2. **Executive Director's Report**
3. **Docket Status - Cases Closed -** None
4. **Docket Status - Cases Open**

   2050A - University of Maryland Medical System
   2051A - Johns Hopkins Health System
   2052A - MedStar Health
   2053A - Johns Hopkins Health System
   2054A - Johns Hopkins Health System
   2055R - Dorchester General Hospital

5. **Final Recommendation Regarding Budgetary Actions of the Board of Public Works**
6. **Draft Recommendation on One-Day Length of Stays and Denied Cases**
7. **Final Recommendation on Nurse Support Program II Guidelines**
8. **Medicare Waiver Update**
9. **Final Recommendation for Revision of the Relative Value Unit Scale of Labor and Delivery**
10. **Hearing and Meeting Schedule**

462nd MEETING OF THE HEALTH SERVICES COST REVIEW COMMISSION

NOVEMBER 4, 2009

Commissioner Hall called the meeting to order at 9:35 a.m. Commissioners Joseph R. Antos, Ph.D., Steven B. Larsen, C. James Lowthers, and Herbert S. Wong, Ph.D. were also present.

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

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

ITEM II
EXECUTIVE DIRECTOR'S REPORT

Robert Murray, Executive Director, updated the Commission on the projects in which staff has been involved in the last month. They include: 1) holding a clinical workgroup meeting to assist hospitals in indentifying solutions for DRGs with high hospital acquired potentially preventable condition (MHAC) rates; 2) working with the industry and Medicaid on the reconciliation of expected and actual averted bad debt; 3) held first workgroup meeting to attempt to determine the adjustments needed to identify potentially preventable readmissions: 4) developed Community Benefit Report evaluation benchmark comparisons to provide feedback to hospitals; 5) scheduled second meeting to review Inter-hospital Cost Comparison and Reasonableness of Charges methodologies to discuss the issues associated with peer groups, direct and indirect medical education adjustments, and utilization of the charge per visit; 6) met with the Centers for Medicare and Medicaid Services (CMS) actuary who agreed make a technical adjustment to the waiver test calculation, which will improve the waiver test cushion by 1.5%; 6) scheduled workgroup meeting to discuss FY 2011 payment update; 7) reached a settlement with Johns Hopkins Bayview Medical Center related to coding irregularities; and 8) detected a technical issue that will result in the Medicaid assessment of $8.9 million approved by the Commission at its October public meeting being increased by $220,000.

Mr. Murray also announced that at the request of the Maryland Hospital Association (MHA), staff agreed to delay the presentation of its draft recommendation on a One Day Length of Stay (1-day LOS) policy. However, staff would like to take some time at today's meeting to provide further background on the issue, solicit input from the industry and the payers, and discuss some potential solutions.

Mr. Murray observed that the CMS Recovery Audit Contractor Program (RAC) is also focusing on 1-day LOS cases in Maryland hospitals because of the higher proportion relative to total admissions when compared to other states and the nation.

Mr. Murray noted that staff believes that the incentives for Maryland hospitals to treat short stay patients on an inpatient basis are much too strong. Even though the cost to treat short stay patients is the same whether treated as inpatients or as outpatients hospitals are able, however, to generate much higher revenues if they are admitted under the HSCRC's Charge per Case (CPC) system than if they were treated as outpatients. In addition, for cases where the admission is denied for medical necessity, hospitals have inappropriately received the full rate capacity of the case.

Mr. Murray stated that staff recommends the removal of cases denied for medical necessity from the CPC system. In addition, staff recommends that as a possible approach to reduce the incentive to admit short stay patients, individual hospital performance should be compared to a more acceptable 1-day LOS level and penalties applied to reduce rate capacity. Staff believes that achieving savings through greater efficiency is a far better way to absorb Medicaid budget reductions than arbitrary revenue cuts. We must also recognize and take into consideration that by reducing 1-day LOS cases, there may be an impact on hospital case mix and a possible impact on the Medicare waiver. In addition, we must address the hospital industry's concern about its ability to appropriately charge for observation services.

Graham Atkinson, Ph.D., HSCRC consultant, presented analyses of data comparing the proportion of 1-day LOS cases in Maryland to New York and California. The data showed that the proportion of 1-day LOS cases in Maryland is slightly higher than New York and significantly higher than California. According to Dr. Atkinson, the Maryland payment system creates an incentive for 1-day LOS cases, and Maryland's relatively short LOS is related to the high number of 1-day LOS.

Charlotte Thompson, Deputy Director-Research and Methodology, summarized the proposed methodology for removing excess 1-day LOS revenue capacity from the CPC system as proposed by staff.

Mr. Murray stated that staff will continue to meet with hospitals and payers to discuss and receive input on this issue with the intention of presenting a draft recommendation at the Commission's December public meeting.

Ms. Carmela Coyle, President & CEO of MHA, reported that hospitals are concerned about the lack of a transparent and accountable process in the development of the 1-day LOS proposal. Ms. Coyle expressed the hope that the delay in presenting the proposed 1-day LOS policy will allow sufficient time for input by stakeholders and for consideration by the Commissioners. Ms. Coyle stated that because this is an extremely complicated issue with potentially significant financial implications, the hospital industry hopes that we can move to a process that provides a greater opportunity for broader participation and broader engagement by stakeholders and Commissioners.

Michael Robbins, Senior Vice President-Financial Policy of MHA, stated that the hospital industry agrees with staff that there should be no financial incentive in the payment system to admit patients versus placing them in an outpatient observation status. However, the industry believes that its recommendations for addressing a more comprehensive approach to this issue must be given due consideration.

Mr. Robbins noted that this is not a new issue. The level of 1-day LOS cases has been relatively unchanged for a number of years. Mr. Robbins stated that the industry has responded to a number of incentives built into the payment system many years ago - - among them, the elimination from the HSCRC payment system of a separate outpatient observation rate almost 20 years ago.

Mr. Robbins pointed out that the current DRG payment system is a system of averages and, therefore, it is inappropriate to focus on the financial impact associated with one part of the system, 1-day LOS cases, without looking at the system as a whole. Mr. Robbins noted that staff's proposed "better practice" standard to reduce 1-day LOS cases has no clinical relevance. According to Mr. Robbins, there are no industry recognized benchmarks as to the appropriate level of 1-day LOS cases. Mr. Robbins asserted that staff's proposal does not take into consideration the complexity of the issue, its impact on the case-mix index (CMI), the lack of an outpatient observation rate, impact on the CMI governor, or the potential impact on the Medicare waiver test.

Mr. Robbins urged: 1) that the Commission in fashioning a final proposal take no action until the full complexity of the issue is researched and accounted for; 2) that due consideration is given to hospital industry recommendations; and 3) that any change should be revenue neutral.

Commissioner Larsen inquired as to the possible reasons for the high proportion of 1-day LOS cases in Maryland hospitals.

Mr. Robbins speculated that it may be that the national data included proportionally more small rural hospitals than the Maryland data. And, these small hospitals, because of their limited resources, may not get short stay patients out as quickly. The result may be less 1-day LOS cases and more 2-day LOS cases than Maryland hospitals. Mr. Robbins suggested that we may want to look at the proportion of 2-day LOS cases in Maryland and the U.S.

Ms. Coyle commented that the issue that merits more consideration is what is the appropriate 1-day LOS benchmark, a clinical standard or a national average?

Commissioner Hall asked why the observation rate center was eliminated.

Dennis Phelps, Associate Director-Audit & Compliance, explained that the separate observation rate center was eliminated because it expanded the definition of observation services inappropriately. The definition included not only cases where the patient was observed in order to determine whether he or she should be admitted or not (true observation), but also included all

zero or 1-day LOS inpatient cases. Because the creation of the observation center effectively did away with all short stay inpatient cases, it adversely affected the Medicare waiver test. As a result, the observation rate center, which was established in August 1988, was abolished January 1, 1990. At that time, the mechanism for charging for true observation cases returned to the Emergency Department.

Commissioner Hall also expressed concern that elimination of 1-day LOS cases might adversely affect the treatment of patient with chest pain, i.e., cardiac cases, in some hospitals.

Mr. Murray stated that the proposed methodology to reduce 1-day LOS cases, like the MHAC methodology recently approved by the Commission, does not focus on individual cases, but attempts to push back in an aggregate manner against the creation of excessive rate capacity.

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Hal Cohen, Ph.D., representing CareFirst of Maryland and Kaiser Permanente, stated that there should be incentives in the payment system to treat patients, if the treatment is clinically equal, where it is less costly. Dr. Cohen asserted that observation is a perfectly appropriate way to treat many patients and should be utilized more by Maryland hospitals.

In regard to the process issue, Dr. Cohen asserted that the payers should be as involved in these discussions as the hospitals. Dr. Cohen also expressed concern that the process may become bogged down if everything has to be agreed to by all parties before a draft recommendation can be presented to the Commission. Dr. Cohen stated that with the current process where staff brings a draft recommendation to the Commission, there is ample opportunity for comment by the stakeholders Thus, when the Commission makes its decision, it is transparent, accountable, and appropriate.

Dr. Cohen stated that the "better practice" standard methodology for reducing the level of 1-day LOS in Maryland hospitals appears to be appropriate.

ITEM III
DOCKET STATUS CASES CLOSED

2041A – Johns Hopkins Health System
2046A – Maryland General Hospital, St. Agnes Hospital, Western Maryland Health System and Washington County Hospital
2049A – Johns Hopkins Health
2045A – MedStar Health
2047A - University of Maryland Medical Center
2048A – University of Maryland Medical Center

ITEM IV
DOCKET STATUS CASES OPEN

There were no cases presented for Commission action.

ITEM V
DRAFT RECOMMENDATION ON ONE DAY LENGTH OF STAY POLICY

At the request of MHA, staff agreed to delay the presentation of its draft recommendation on a proposed one day length of stay policy.

ITEM VI
DRAFT RECOMMENDATIONS FOR REVISION OF THE LABOR AND DELIVERY RELATIVE VALUE UNIT SCALE

Rodney Spangler, Chief-Audit & Compliance, requested Commission approval to promulgate for review and public comment proposed revisions to the Relative Value Unit Scale of Labor and Delivery Services.

The Commission voted unanimously to grant staff's request.

ITEM X
LEGAL REPORT

Regulations

Final Adoption

Uniform Accounting and Reporting System for Hospitals and Related Institutions – COMAR 10.37.01.03

The purpose of this action is to correct erroneous references to "quarterly" reporting requirements when, in fact, these requirements are, and have been, monthly in nature.

The Commission voted unanimously to adopt these amended regulations.

ITEM XI
HEARING AND MEETING SCHEDULE

January 13, 2009	Time to be determined, 4160 Patterson Avenue, HSCRC Conference Room

February 3, 2010	Time to be determined, 4160 Patterson Avenue, HSCRC Conference Room

There being no further business, the meeting was adjourned at 10:49 a.m.

Final Recommendation for an Alternative Method of Financing Board of Public Works Approved Medicaid Payment Reductions

December 9, 2009

This recommendation was approved by the Commission on December 9, 2009.

Background

On November 18, 2009, the Board of Public Works (BPW) announced another round of budgetary cuts and approved a recommendation to cut expenditures for hospital care by $21.3 million effective January 1, 2010. This reduction is in addition to a $10 million expenditure reduction approved as part of the Budget bill (Supplemental Budget #2), passed by the General Assembly in April, 2009.

The $10 million reduction in Medicaid expenditures was included in the Budget bill in the event the Governor's bill to enhance the State's ability to pursue fraud and abuse in the Medicaid program did not pass (SB 272 – The Maryland False Health Claims Act of 2009). The Maryland Hospital Association strongly opposed this legislation, and the False Claims act was narrowly defeated by one vote in the Maryland Senate.

Because Medicaid expenditures are funded through a combination of State and federal sources (38.5% State and 61.5% federal), in order to generate the needed $21.3 million in BPW reductions, Medicaid must reduce expenditures by over $55 million over the next six months ($110 million on an annualized basis). The same circumstance also applies to the $10 million Budget bill cut. In order to generate this level of savings, an expenditure cut of over $25 million would be required over the final six months of FY 2010 (or in excess of $50 million on an annualized basis). Thus, the generation of these needed budget savings through reductions in Medicaid expenditures would necessitate a massive $80 million expenditure cut over the next 6 months (or $160 million reductions on an annualized basis).

As was the case for both the July and August cuts, the BPW action also gave the HSCRC an opportunity to craft an "alternative" plan to generate the needed cost savings. Any alternative plan, however, must be approved before January 1, 2010, or the State will be forced to implement the needed expenditure reductions as planned. These reductions would be in the form of eliminating hospital coverage for inpatient services for the so-called "Medically Needy" population.

Previous HSCRC Action Related to the July and August Cuts

In October 2009, the HSCRC approved an alternative plan to fund the July and August budget reductions approved by the BPW at its July and August meetings (cuts totaling $13.4 million) in response to declining State revenue projections ($8.9 million and $4.5 million reductions were approved at the July and August meetings respectively). The HSCRC alternative approach made use of both an assessment on hospital rates of $8.9 million and a total remittance from hospitals to the Department of Health of $13.4 million during FY 2010. The net effect of this action was to

fund $8.9 million of the total BPW cut from assessments on hospital rates (extra amounts paid by payers and patients), and $4.5 million funded directly from hospitals' operating budgets.[1]

While this alternative approach was far less deleterious than a direct expenditure reduction (totaling over $160 million on an annualized basis) on the part of the Maryland Medicaid program, assessing hospital rates to generate the needed savings contributes to the worsening health care affordability problem in the State and also negatively affects the State's performance on the Medicare wavier test. Discussion of this alternative at the time of Commission approval also focused on whether this particular split ($8.9 million funded by payers and $4.5 million funded directly by hospitals) represented the fairest distribution of the FY 2010 budget action, particularly in light of the distribution of current (FY 2010) and past budgetary reductions (FY 2003-2009).

Consideration of All Budget Reductions Collectively

The July, August, and November BPW reductions now represent the total of reductions that could feasibly be applied through the All-Payer hospital rate system for FY 2010. As such, staff believes it is important to craft an overall alternative approach that generates the needed budgetary savings in a fair and equitable way, but, at the same time, minimizes negative impacts on patients, hospitals, and payers.

Accordingly, the "alternative approach" developed by the HSCRC should represent a balancing of the following policy goals and principles:

a) the need to more "efficiently" generate the needed budget savings – relative to the State's alternative of massive expenditure reductions;
b) fairness in application - in terms of who bears the burden of these cuts (the burden of historical and existing 2010 budget cuts have fallen disproportionately on non-hospital providers and payers – see appendix I and appendix II);
c) the need to minimize (the extent possible) further increases in the cost of health care in Maryland – which serves to reduce affordability and access to care at a time when most state and federal reform initiatives are geared toward increasing affordability and expanding access;
d) the need to avoid further eroding the Medicare waiver performance;
e) the burden of such actions on the hospital industry in the context of a lower than normal update factor in 2010 and other significant rate adjustments either implemented or planned to be implemented in FY 2010.

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[1] The proportions of these reductions shared by hospitals and payers were as a result of the staggered nature of the budget cuts. Staff originally recommended in September that the full $8.9 million from the July BPW action be funded through an assessment. With the additional $4.5 million reduction resulting from the August BPW action, staff believed that there should be some sharing of these cuts between hospitals and payers, and, thus, the recommended that Maryland hospitals directly shoulder this part of the expenditure reductions.

Additionally, any alternative action developed by the HSCRC must be finalized in December to avert the need for the Department of Health to take more dramatic and deleterious action effective January 1, 2010.

Based on the above factors and policy considerations, the staff proposes the following alternative for financing the collective $34.7 million BPW approved cuts (July, August, and November) and the $10 million Medicaid expenditure reductions per the Supplemental Budget #2 of the 2009 Budget Bill.

First, based on the circumstances involved, the $10 million expenditure reduction in the 2009 Budget bill should be funded directly from hospitals in the form of a remittance to the Department of Health with no commensurate rate assessment.

Second, given the need to share the burden of budget cuts fairly and to minimize further erosions to the affordability of hospital care and negative impacts on the State's Medicare waiver, staff believes it is appropriate to allocate the collective $34.7 million BPW cuts equally between payers and hospitals.[2] This would result in assessments on hospital rates sufficient to generate $17.35 million (add-ons to the rates paid by payers for a 6 month period January –June 2010) and a direct remittance from hospitals of $34.7 million (both these assessed amounts and the hospitals' portion of the cuts). In this circumstance, the hospitals would collect half of the required savings from payers, but then add to that amounts provided by hospitals from their own operating budgets.

Based on previous Commission action (in reaction to the earlier and incomplete BPW budgetary actions), the payers were to fund $8.9 million through assessments on hospital rates, and the hospitals were to fund $4.5 million from operating budgets. In light of these more recent cuts – and per the staff recommendations, both parties are now being asked to fund equal portions of the overall cut (an additional $8.45 million from payers and an additional $12.85 million directly from hospitals).

Medicaid "Feedback" Effect

Finally, the application of further assessments to rates paid by payers creates an additional "feedback" effect to the Medicaid program. The feedback effect occurs when hospital rates are increased, and Medicaid pays a portion of this increase throughout the year. Under this scenario, the net budgetary impact to Medicaid is actually something less than the targeted amount since

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[2] Staff would note, however, that non-hospital providers and payers/patients have disproportionately borne the largest proportions of past Medicaid budget cuts (both FY 2010 cuts and FY 2003 -2009 cuts). Appendix I to this recommendation is an excerpt from an analysis that shows how non-hospital providers have been impacted by past budgetary cuts. While fees to nursing homes, physicians and other non-hospital providers have either gone down or been flat over this period, acute care hospitals have realized cumulative rate increases in nearly 50% (compounded since 2003).

payments have increased. To rectify this, rates are increased to an amount that results in the net desired savings for the Medicaid program.

Therefore, under these recommendations, if rates are increased by $17.35 million to address the various budget cuts, the feedback effect relative to payment associated with Fee-for-Service Medicaid enrollees would be 6.1% of this amount – or $1.06 million. Staff is proposing that this feedback effect be shared equally between payers and hospitals - $529,300 each.

The table below shows how the various amounts were calculated and the ultimate remittance that needs to be made to the Department of Health: a total remittance of $45.8 million (generated in part by a $17.9 million assessment on hospital rates).

Calculation of Deficit Assessment

January 1, 2010 through June 30, 2010

		Hospital Portion	Payer Portion	Total Paid to Medicaid by Hospitals
Board of Public Works Cuts				
BPW's July 2009 Cut	$8,897,720	0	$8,897,720	
BPW's August 2009 Cut	$4,532,380	$4,532,380	0	
BPW's November 2009 Cut	$21,279,382	$12,822,361	$8,457,021	
Total BPW's Cuts	$34,709,482	$17,354,741	$17,354,741	$34,709,482
Hospital/Payer Split 50% /50%				
Feedback Effect of Rate Increase				
Payer Portion of BPW's Cuts	$17,354,741			
Medicaid Fee for Service Percent	6.10%			
Total Feedback Effect	$1,058,639	$529,320	$529,320	$1,058,639
Hospital/Payer Split 50% /50%				
Supplemental Budget Cut FY 2010	$10,000,000	$10,000,000	0	$10,000,000
Hospital Pays 100%				
Total Hospital/Payer Portion		$27,884,061	$17,884,061	$45,768,121

Final Staff Recommendations

Based on the analysis above, the staff recommends the following action related to the funding of the Medicaid Expenditure reduction from the Supplemental budget #2 of the 2009 Budget bill of $10 million, and the July, August, and November 2009 Board of Public Work budget cuts totaling $34.7 million (and associated feedback impact):

1. Provide an assessment on hospital rates sufficient to generate $17,354,741, plus an additional $539,320 (for the associated Medicaid feedback effect), beginning January 1, 2010 and ending June 30, 2010. These amounts (a total of $17,884,061) and represent a 50% share of the BPW budget cuts and associated Medicaid feedback impact assigned to the paying public.

2. Hospitals remit a total of $17,884,061 ($17,354,741 BPW cut + $539,320 feedback portion) generated through assessments on payers, plus $27, 884,061 ($10,000,000 associated with the recommendations of the Supplement #2 of the 2009 Budget bill, $17, 354,741 associated with a 50% share of BPW cuts, and $539,320 in associated Medicaid feedback effects), for a total amount remitted to the Department of Health over the period January through June of 2010 of $45,768,122. Tables 1 and 2 show how these amounts would be applied across the hospital and payer industries. These amounts should be remitted to the Department on a monthly basis at 1/6 increments over this period.

Appendix I – Calculation of Amounts by Hospital

Calculation of Deficit Assessment

January 1, 2010 through June 30, 2010

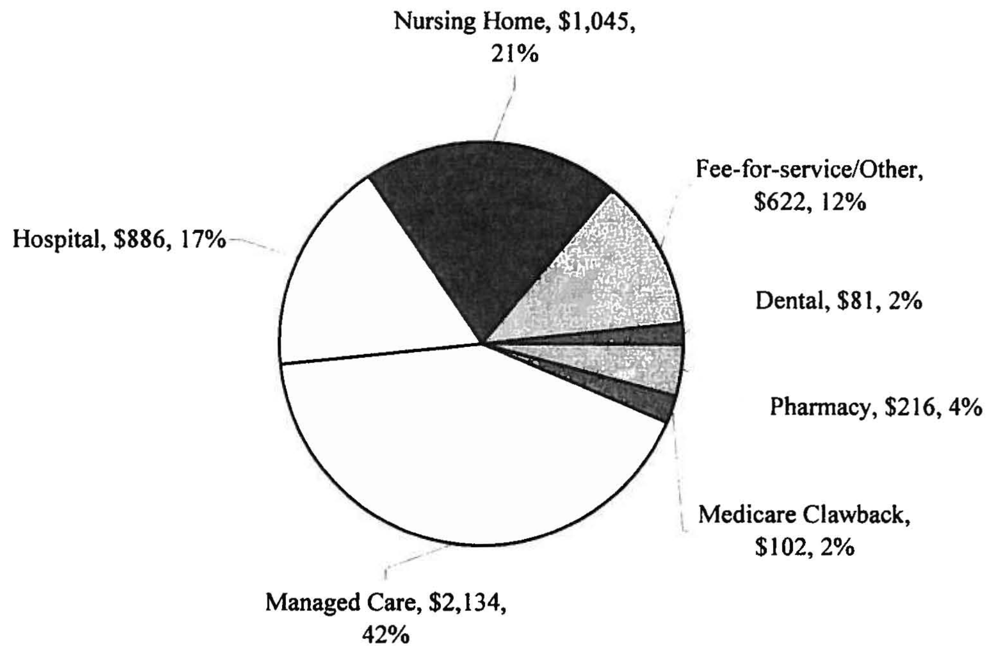
	Estimated Annualized Hospital Revenue	Hospital Portion of BPW Cuts	Medicaid Feedback Effect	Supplemental Budget Cuts	Total Hospital Portion	Payer Portion of BPW Cuts	Medicaid Feedback Effect	Total Payer Portion
210001 Washington County Hospital	$249,540,192	$334,074	$10,189	$192,497	$536,761	$334,074	$10,189	$344,263
210002 Univ. of Maryland Medical System	$985,764,064	$1,319,700	$40,251	$760,426	$2,120,377	$1,319,700	$40,251	$1,359,951
210003 Prince Georges Hospital	$282,270,472	$377,892	$11,526	$217,746	$607,163	$377,892	$11,526	$389,418
210004 Holy Cross Hospital of Silver Spring	$402,456,306	$538,792	$16,433	$310,458	$865,683	$538,792	$16,433	$555,225
210005 Frederick Memorial Hospital	$269,176,239	$360,362	$10,991	$207,645	$578,998	$360,362	$10,991	$371,353
210006 Harford Memorial Hospital	$99,016,011	$132,559	$4,043	$76,382	$212,983	$132,559	$4,043	$136,602
210007 St. Josephs Hospital	$379,157,173	$507,600	$15,482	$292,485	$815,567	$507,600	$15,482	$523,082
210008 Mercy Medical Center, Inc.	$386,351,789	$517,232	$15,776	$298,035	$831,042	$517,232	$15,776	$533,007
210009 Johns Hopkins Hospital	$1,621,150,439	$2,170,329	$66,195	$1,250,568	$3,487,092	$2,170,329	$66,195	$2,236,524
210010 Dorchester General Hospital	$53,166,583	$71,177	$2,171	$41,013	$114,361	$71,177	$2,171	$73,348
210011 St. Agnes Hospital	$367,886,780	$492,512	$15,022	$283,791	$791,324	$492,512	$15,022	$507,533
210012 Sinai Hospital	$637,224,673	$853,090	$26,019	$491,560	$1,370,669	$853,090	$26,019	$879,109
210013 Bon Secours Hospital	$128,130,046	$171,535	$5,232	$98,841	$275,608	$171,535	$5,232	$176,767
210015 Franklin Square Hospital	$428,304,605	$573,396	$17,489	$330,398	$921,283	$573,396	$17,489	$590,885
210016 Washington Adventist Hospital	$285,998,476	$382,883	$11,678	$220,621	$615,182	$382,883	$11,678	$394,561
210017 Garrett County Memorial Hospital	$38,624,014	$51,708	$1,577	$29,795	$83,080	$51,708	$1,577	$53,285
210018 Montgomery General Hospital	$139,948,313	$187,357	$5,714	$107,957	$301,029	$187,357	$5,714	$193,071
210019 Peninsula Regional Medical Center	$378,825,277	$507,156	$15,468	$292,229	$814,853	$507,156	$15,468	$522,624
210022 Suburban Hospital Association,Inc	$227,512,454	$304,584	$9,290	$175,505	$489,379	$304,584	$9,290	$313,874
210023 Anne Arundel General Hospital	$383,922,692	$513,980	$15,676	$296,161	$825,817	$513,980	$15,676	$529,656
210024 Union Memorial Hospital	$414,932,297	$555,494	$16,943	$320,082	$892,519	$555,494	$16,943	$572,437
210025 The Memorial Hospital	$102,655,083	$137,430	$4,192	$79,189	$220,811	$137,430	$4,192	$141,622
210027 Braddock Hospital	$161,791,651	$216,600	$6,606	$124,807	$348,014	$216,600	$6,606	$223,206
210028 St. Marys Hospital	$125,984,232	$168,662	$5,144	$97,185	$270,992	$168,662	$5,144	$173,807
210029 Johns Hopkins Bayview Med. Cente	$524,764,932	$702,533	$21,427	$404,808	$1,128,769	$702,533	$21,427	$723,961
210030 Chester River Hospital Center	$62,219,037	$83,296	$2,541	$47,996	$133,833	$83,296	$2,541	$85,837
210032 Union Hospital of Cecil County	$130,725,788	$175,010	$5,338	$100,843	$281,191	$175,010	$5,338	$180,348
210033 Carroll County General Hospital	$191,119,793	$255,863	$7,804	$147,431	$411,098	$255,863	$7,804	$263,667
210034 Harbor Hospital Center	$211,053,140	$282,549	$8,618	$162,808	$453,975	$282,549	$8,618	$291,167
210035 Civista Medical Center	$105,225,964	$140,872	$4,297	$81,172	$226,341	$140,872	$4,297	$145,169
210037 Memorial Hospital at Easton	$159,526,151	$213,567	$6,514	$123,060	$343,141	$213,567	$6,514	$220,081
210038 Maryland General Hospital	$198,071,502	$265,170	$8,088	$152,794	$426,052	$265,170	$8,088	$273,258
210039 Calvert Memorial Hospital	$110,562,013	$148,016	$4,514	$85,288	$237,819	$148,016	$4,514	$152,530
210040 Northwest Hospital Center, Inc.	$216,456,216	$289,783	$8,838	$166,976	$465,597	$289,783	$8,838	$298,621
210043 Baltimore Washington Medical Centr	$313,163,009	$419,250	$12,787	$241,576	$673,613	$419,250	$12,787	$432,037
210044 Greater Baltimore Medical Center	$374,157,738	$500,907	$15,278	$288,628	$804,813	$500,907	$15,278	$516,184
210045 McCready Foundation, Inc.	$16,884,205	$22,604	$689	$13,025	$36,318	$22,604	$689	$23,293
210048 Howard County General Hospital	$228,955,673	$306,516	$9,349	$176,618	$492,483	$306,516	$9,349	$315,865
210049 Upper Chesapeake Medical Center	$208,684,992	$279,379	$8,521	$160,981	$448,881	$279,379	$8,521	$287,900
210051 Doctors Community Hospital	$194,371,404	$260,216	$7,937	$149,940	$418,093	$260,216	$7,937	$268,153
210054 Southern Maryland Hospital	$230,408,030	$308,461	$9,408	$177,739	$495,607	$308,461	$9,408	$317,869
210055 Laurel Regional Hospital	$97,504,356	$130,535	$3,981	$75,216	$209,732	$130,535	$3,981	$134,516
210056 Good Samaritan Hospital	$282,846,370	$378,663	$11,549	$218,190	$608,402	$378,663	$11,549	$390,212
210057 Shady Grove Adventist Hospital	$322,904,485	$432,291	$13,185	$249,091	$694,567	$432,291	$13,185	$445,476
210058 James Lawrence Kernan Hospital	$106,886,587	$143,095	$4,364	$82,453	$229,913	$143,095	$4,364	$147,460
210060 Fort Washington Medical Center	$51,356,692	$68,754	$2,097	$39,617	$110,468	$68,754	$2,097	$70,851
210061 Atlantic General Hospital	$75,672,270	$101,307	$3,090	$58,374	$162,771	$101,307	$3,090	$104,397
STATE-WIDE	$12,963,310,208	$17,354,741	$529,320	$10,000,000	$27,884,061	$17,354,741	$529,320	$17,884,061
Percent of Total Revenue					0.22%			

BPW's July 2009 Cut	$8,897,720
BPW's August 2009 Cut	$4,532,380
BPW's November 2009 Cut	$21,279,382
Total BPW's Cuts	$34,709,482
Hospital/Payer Split 50% /50%	
Hospital/Payer Split of BPW's Cuts	$17,354,741

Appendix II – Trends in Provider Rate Increases per the DHMH Budget Analysis 2009

Exhibit 11 presents the proposed allocation of provider reimbursement dollars among service type.

Exhibit 11
Provider Reimbursements by Services Type
Fiscal 2010
($ in Millions)



Source: Department of Health and Mental Hygiene

Exhibit 12 shows the trends in rate increases for providers. As shown, most providers do not receive a rate increase in the fiscal 2010 allowance. The exceptions are the Older Adults Waiver, the Living at Home Waiver Program, and MCOs. The Older Adults Waiver, the Living at Home Waiver Program, and the Medical Day Care Waiver receive a 0.9% rate increase in fiscal 2010, equivalent to the rate increase provided to community-based providers in the Developmental Disabilities, Mental Hygiene, and the Alcohol and Drug Abuse administrations. This rate increase is intended for non-labor related costs of the waiver programs.

Exhibit 12
Trends in Selected Provider Rate Increases
Fiscal 2005-2010

	2005	2006	2007	2008	2009	Proposed 2010	Avg. Annual Increase 2005-2009
Managed Care Organizations*	5.8%	6.3%	5.2%	6.7%	4.3%	5.1%	5.7%
Personal Care	0.0%	10.0%	9.1%	4.1%	2.0%	0.0%	5.0%
Nursing Homes	3.8%	1.5%	5.0%	4.0%	4.4%	0.0%	3.7%
Private Duty Nursing	0.0%	0.0%	10.0%	0.0%	2.0%	0.0%	2.4%
Medical Day Care Waiver	2.7%	3.6%	3.0%	0.0%	2.0%	0.9%	2.3%
Home Health	3.3%	2.5%	1.7%	0.0%	2.0%	0.0%	1.9%
Living at Home Waiver	2.5%	2.5%	1.7%	0.0%	2.0%	0.9%	1.7%
Older Adults Waiver	2.0%	2.0%	1.7%	0.0%	2.0%	0.9%	1.5%

* Managed Care Organizations (MCOs) receive rate increases on a calendar year basis. The calendar 2008 increase was offset by the HIV/AIDS drug carve out, which if taken into account resulted in a 4.4% increase. The calendar 2010 rate is an estimate based on recent experience.

Source: Department of Health and Mental Hygiene; Department of Legislative Services

MCO rate increases are different from other providers. First of all, the rate increases are administered according to the calendar year rather than the fiscal year. Also, the federal government requires the State to provide Medicaid MCOs with an actuarially sound rate increase.

Physician and Dental Rates

Physician and dental rates were expected to be enhanced in fiscal 2010, but both were level funded in the fiscal 2010 allowance. Fiscal 2010 is the first year that by statute all the Rate Stabilization Fund revenue is dedicated to Medicaid, which means fiscal 2010 was the last year for physician rates to receive a rate enhancement from increased revenue from the Rate Stabilization Fund. The fiscal 2010 baseline budget prepared by DLS assumed the fiscal 2010 Rate Stabilization Fund revenue would be dedicated to a physician rate enhancement which would have been an increase of $11 million in special funds and $22 million in total funds. Instead of funding the physician rate enhancement, the additional special funds from the Rate Stabilization Fund are reducing the need for general funds.

Appendix III – Cost Containment Actions DHMH 2009-2010

12/2/2009

Department of Health and Mental Hygiene General Fund Cuts
Fiscal Year 2009-2010 BPW Cost Containment Actions

	FY 2009 Round #1	FY 2009 Round #2	FY 2009 Round #3	FY 2010 Round #1	FY 2010 Round #2	FY 2010 Round #3	FY09-FY10 Combined	% of Total	FY 2010 GF Budget	% of Total
Administration	506	631	334	997	423	736	3,627	1%	38,800	1%
Public Health	5,711	7,510	787	1,637	32,642	794	49,081	13%	188,251	4%
ADAA	-	988	-	1,225	1,675	1,859	5,747	2%	94,890	2%
Mental Hygiene Community	-	6,408	2,650	3,131	6,258	7,500	25,947	7%	376,059	9%
DD Community	-	2,509	-	5,275	10,077	300	18,161	5%	445,495	11%
Mental Hygiene Facilities	703	2,931	1,381	9,436	6,903	3,521	24,875	7%	282,441	7%
DD Facilities	400	1,159	-	2,079	1,864	-	5,502	1%	48,907	1%
Total Behavioral Health	1,103	13,995	4,031	21,146	26,777	13,180	80,232	22%	1,247,792	30%
Medical Care Programs	12,039	49,691	5,138	120,955	22,048	29,493	239,364	64%	2,749,953	65%
Total DHMH	19,359	71,827	10,290	144,735	81,890	44,203	372,304	100%	4,224,796	100%

FY 2010 Totals

	FY 2010 Round #1	FY 2010 Round #2	FY 2010 Round #3	FY09-FY10 Combined	% of Total	FY 2010 GF Budget	% of Total
Administration	997	423	736	2,156	1%	38,800	1%
Public Health	1,637	32,642	794	35,073	13%	188,251	4%
ADAA	1,225	1,675	1,859	4,759	2%	94,890	2%
Mental Hygiene Community	3,131	6,258	7,500	16,889	6%	376,059	9%
DD Community	5,275	10,077	300	15,652	6%	445,495	11%
Mental Hygiene Facilities	9,436	6,903	3,521	19,860	7%	282,441	7%
DD Facilities	2,079	1,864	-	3,943	1%	48,907	1%
Total Behavioral Health	21,146	26,777	13,180	61,103	23%	1,247,792	30%
Medical Care Programs	120,955	22,048	29,493	172,496	64%	2,749,953	65%
Total DHMH	144,735	81,890	44,203	270,828	100%	4,224,796	100%

Final Recommendation:

The Establishment of Guidelines for the Nurse Support Program II

December 9, 2009

This recommendation was approved by the Commission on December 9, 2009.

NURSE SUPPORT PROGRAM II GUIDELINES

Section 11-405(e) of the Education Article of the Annotated Code of Maryland provides that Nurse Support Program II (NSPII) funds shall be used in accordance with guidelines established by the Health Services Cost Review Commission and the Maryland Higher Education Commission. This recommendation establishes the guidelines for the NSPII program.

A. PURPOSE

The Health Services Cost Review Commission (HSCRC) approved the creation of the Nurse Support Program II (NSP II) on May 4, 2005, in order to alleviate the critical shortage of qualified nurses in Maryland by expanding the capacity of Maryland nursing schools. The program is scheduled to be funded for up to ten years by a 0.1% increase to regulated gross patient revenue. NSP II focuses on expanding the capacity to educate nurses, with specific attention given to educating nurses to become faculty members.

B. ADMINISTRATION

The HSCRC contracted with the Maryland Higher Education Commission (MHEC) to administer NSP II, which includes developing applications and guidelines, overseeing the review and selection of applicants, conducting site visits, and monitoring and evaluating NSP II. MHEC provides the programmatic and administrative support necessary for the successful administration of the NSP II program. MHEC is compensated an agreed-upon amount from NSP II funds each year to perform its administrative duties.

C. NSP II Program Description

Under Nurse Support Program II, two components are authorized:

1) Competitive Institutional Grants
2) Statewide Initiatives (which include)
    a. Graduate Nursing Faculty Scholarship
    b. Living Expenses Grant
    c. New Nursing Faculty Fellowship
    d. Loan Assistance Repayment for New Nursing Faculty

Competitive Institutional Grants

Competitive Institutional Grants are awarded to eligible applicants consisting of: 1) a consortia of Maryland institutions of higher education with nursing degree programs and Maryland hospitals; 2) individual Maryland higher education institutions with nursing degree programs partnered with several Maryland hospitals; 3) individual Maryland higher education institutions with nursing degree programs; or 4) partnerships of Maryland higher education institutions with nursing degree programs through a

competitive Request for Applications process. The size of each Competitive Institutional Grant award will depend upon the grant project's ability to impact the nursing shortage in a timely manner, the depth and breadth of the initiative, and the feasibility of the budget.

In the annual Request for Applications, MHEC, in consultation with HSCRC staff, will designate initiatives that are eligible for funding. In FY 2010, allowable initiatives included:

- Initiatives to expand Maryland's nursing capacity through shared resources of schools of nursing and hospitals, allowing for immediate expansion of nursing enrollments and graduates.

- Initiatives to increase Maryland's nursing faculty through the implementation of sustainable strategies to increase the supply of nursing faculty by increasing enrollments and enhancing or creating graduate nursing programs.

- Initiatives to increase nursing student retention through strategies such as tutoring, mentoring, on-line testing.

- Initiatives to increase the pipeline for nursing faculty by increasing the proportion of students entering community colleges who transition into baccalaureate degree programs immediately after completion of community college.

- Initiatives to increase capacity statewide through development of innovative statewide programs in areas such as faculty development, simulation training, student retention, preceptor training.

MHEC will establish a review panel to evaluate all applications and make recommendations regarding the selection of proposals that best meet established goals for this program. Each proposal will be evaluated based on the criteria described in the proposal narrative section and summarized below. The rating given for each criterion will serve as a significant, but not exclusive aspect of the judgment made by the review panel. State priorities, support of diversity, and regional needs will also be taken into consideration. The panel also makes recommendations on the level of funding and adjustments that the project staff might make to improve the project. The recommendations of the review panel will be presented to the HSCRC, which will make the final determination.

Projects may range from three to five years. MHEC, in collaboration with the staff of the HSCRC, reserves the right to request changes to the original plan and the right to end the grant if deemed necessary.

Grantees may wish to request changes to the original plan once a project is underway. Approval must be received from MHEC before such changes are made.

Annual progress reports are required each year.

Statewide Initiatives

Statewide Initiatives provide funding to individual students and faculty using application processes. The authorized initiatives are:

- *Graduate Nursing Faculty Scholarships* are available to eligible students who are sponsored by Maryland higher education institutions to complete the graduate education necessary to become qualified nursing faculty at Maryland institutions.

  The maximum total award per graduate student is $26,000 for tuition and fees. Students may receive up to $13,000 per year, which is pro-rated for part-time students. Recipients must sign a promissory note pledging to work as nursing faculty after receiving their graduate degrees or must repay the scholarship. The number of awards is dependent upon the number of applications and availability of funds.

- *Living Expenses Grants* are awarded to those recipients of the Graduate Nursing Faculty Scholarship who show need through submission of federal tax returns and W-2s. Awards may total $50,000 per applicant over the course of graduate studies, with a maximum of $25,000 per year.

- *New Nursing Faculty Fellowships* are provided to eligible, recently-hired nursing faculty members. Maryland institutions may nominate any number of newly-hired (within the past year) full-time, tenure-track faculty. Full-time clinical-track faculty who have a long-term contract with a Maryland school of nursing also may be eligible.

  The maximum award amount is $20,000, with $10,000 distributed the first year, and $5,000 distributed in each of the following two years, provided the faculty member is still employed in good standing. These funds must not replace any portion of the nursing faculty fellow's regular salary, but may be used as a supplement or to assist fellows with professional expenses, such as loan repayment, professional development, and other relevant expenses. The number of awards is dependent upon the number of nominations and the availability of funds.

- *Loan Assistance Repayment Program (through the Janet L. Hoffman Loan Assistance Repayment Program)* is for Maryland residents who are nursing faculty. Awards are determined by applicants' overall reported educational debt at the time of application. Applicants will be ranked according to graduation date and then application date. Priority is given to individuals who have graduated from an institution of higher education in the last three years.

  The awards are based on each applicant's overall reported educational debt. Award funds are distributed over three years provided the recipient remains eligible and submits required documentation.

D. Continuing Non-lapsing Special Fund

Legislation was enacted to create a non-lapsing special fund that is not subject to Section 7-302 of the State Finance and Procurement Article. The NSPII fund shall consist of revenue generated through an increase to rates of all Maryland hospitals, as approved by the HSCRC. Any interest earned on the fund shall be paid into the fund and shall not revert to the General Fund.

These NSP II Special Funds may only be used for authorized NSP II initiatives, including grants and awards as designated and approved by the HSCRC and MHEC.

Recommendation

Staff recommends approval of these guidelines to comply with the provisions of Section 11-405(e) of the Education Article of the Annotated Code of Maryland. If adopted, the Commission will submit the approved guidelines to the Maryland Higher Education Commission for final approval.

STAFF RECOMMENDATION

December 9, 2009

The Commission staff recommends for final adoption a revision to the Relative Value Unit (RVU) Scale of Labor and Delivery Services (DEL). These revised RVUs were developed by the Maternal Child Health Directors (MCHD). The MCHD group represents all Maryland hospitals that have obstetric services. The RVU scale was updated to reflect the current services provided to obstetric patients for DEL services. The basis of 1 RVU for fifteen minutes of nursing care has not changed. These RVUs were approved by the Maryland Hospital Association's HSCRC Technical Issues Task Force. At your direction, staff sent this proposed revision to hospitals for review and public comment. Non-substantive corrections and enhancements were made in response to the comments received. Hospitals will be required to calculate conversion factors to assure no change in hospital revenue as a result of this revision. Hospitals will begin using these revised RVUs July 1, 2010.

This recommendation was approved by the Commission on December 9, 2009.

APPENDIX D
STANDARD UNIT OF MEASURE REFERENCES

Account Number	**Cost Center Title**
7010	**Labor and Delivery Service**

Labor and Delivery Service

The Labor and Delivery Relative Value Units were developed by the Maryland Hospital Association. These relative value units will be used to determine the output and charges of the Labor and Delivery Cost Center.

All time reflects standard of 1 RVU = 15 minutes of direct RN care. Charges made to Labor and Delivery RVUs must reflect entire procedure or event occurring in the Obstetrical suite without duplication, support, or charges to other areas using RVUs, minutes, or hours per patient day at the same time. An example is that a short stay D & C cannot be charged RVUs plus OR minutes; a sonogram cannot be charged RVUs to Labor and Delivery and to Radiology. Each institution should designate where a procedure is to be charged based on where that procedure is performed.

Primary Obstetrical Procedures:

These procedures include physical assessment, pregnancy history, and vital signs. RVUs are assigned on the basis of RN time only in relation to these procedures. These charges may be in addition to Obstetrical charges if inpatient or outpatient Observation charges. (See section to follow entitled: L & D Observation/Triage services.)

Note: 1 RVU = 15 minutes of direct RN care

Procedure:	RVUs:	(CPT CODE)
Amniocentesis	3	(CPT 59000)
Biophysical Profile with NST	5	(CPT 76818)
Central Line Placement	2	(CPT 36556)
Cervical Cerclage	10	(CPT 59320)
Dilation & Curettage (D & C)	9	(CPT 59840)
Dilation and Evacuation (D & E)	9	(CPT 59841)
Doppler Flow Evaluation	1	(CPT 93976)
External Cephalic Versions	10	(CPT 59412)
Electronic Fetal Monitoring	1 per hour	(CPT 59050)
Minor Surgery Short stay w/o Delivery (wound care, I&D, Bartholin Cyst treatment, cerclage removal)	9	(CPT 58999)
Non Stress Test, Fetal	5	(CPT 59025)
Oxytocin Stress Test	5	(CPT 59020)
Periumbilical Blood Sampling (PUBS)	18 (+ 4 w/multiples)	(CPT 59012)
Periumbilical Blood Sampling (PUBS) double set up w/OR	2	(CPT 59012)
Scalp PH, fetal	1	(CPT 59030)
Spinal headache treatment	2	(CPT 59899)
Ultrasound, OB (read by Obstetrics only)	3	(CPT 76805)

APPENDIX D
STANDARD UNIT OF MEASURE REFERENCES

DELIVERY Procedures: (SELECT ONLY ONE)	RVUs:	(CPT Code)
Induction/Augmentation without Delivery	1/ hour	(CPT 59899)
Fetal Demise 1st trimester	3	(CPT 59812)
Spontaneous Loss/Genetic Termination 2nd Trimester	24	(CPT 59850)
Spontaneous Loss/Genetic Term. 2nd Trim w/Epidural	30	(CPT 59850)
Delivery Outside Department	12	(CPT 59414)
Vaginal Delivery (No anesthesia, uncomplicated)	24	(CPT 59410)
Vaginal Delivery w/Vacuum/Forceps Assistance	26	(CPT 59410)
Vaginal Delivery w/Epidural Anesthesia	30	(CPT 59410)
Vaginal Delivery w/Epidural w/Forceps/Vacuum Assistance	32	(CPT 59410)
Vaginal Delivery after prior C-section (VBAC)	32	(CPT 59610)
Cesarean Section, Scheduled	18	(CPT 59515)
Cesarean Section, Scheduled w/Added Surgery (Tubal)	20	(CPT 59515)
Cesarean Section, Non-Scheduled Emergency	37	(CPT 59515)
Cesarean Section, Non-Scheduled Emergency w/Tubal	39	(CPT (59515)
Hysterectomy/other major operative procedure, scheduled	18	(CPT 58150)
Cesearean Section with other major OR procedure	38	(CPT (59515)
Major OR procedure , Non-scheduled, w/o Delivery	38	(CPT 58150)

OBSTETRICAL ADD ON TO DELIVERY PROCEDURES:

ADD ON Procedures: (ALL THAT APPLY)	RVUs:	(CPT CODE)
Amnioinfusion	6	(CPT 59070)
Double Set-Up/Failed Forceps/Vacuum	2	(CPT 59410)
Epidural, Repeat Catheter placement	2	(CPT 01967)
Fetal Demise, 3rd Trimester	6	(CPT 59812)
Induction/Augmentation with Delivery	1/ hour	(CPT59899)
Intrauterine Pressure Catheter Monitoring (IUPC)	2	(CPT 59899)
Multiple Birth: Twins	6	(CPT 59410)
Multiple Birth: Triplets	9	(CPT 59410)
Multiple Birth: Quads	12	(CPT 59410)
Neonatal Ongoing Assessment (up to 4 hours)	1/hour	(CPT 99464)
Neonatal Resuscitation (APGAR < 6 @ 1 minute; PH < 7.2)	4	(CPT 99465)
Surgery, Additional Minor (Tubal, placental removal)	8	(CPT 58600)
Surgery, Major OR procedure, unscheduled, emergency	38	(CPT 58150)
Unregistered patient, no prenatal care	4	(CPT 59899)

MISCELLANEOUS PROCEDURES	**RVUs:**	**(CPT code)**
Circumcision (even if performed in Nursery)	3	(CPT 54150)
Newborn Audiology: Auditory Brainstem Response (ABR)	1	(CPT 92585)
Newborn Audiology: Otoacoustic Emission Screen (OAE)	1	(CPT 92587)
Oocyte Retrieval	10	(CPT 58970)
Gamete Intrafallopian Tube Transfer (GIFT)/Tubal Embryo Transfer	16	(CPT 58976)

Note: For any L & D OR suite procedure, RVUs or Minutes may be charged, but not both).

APPENDIX D
STANDARD UNIT OF MEASURE REFERENCES

L & D OBSERVATION AND TRIAGE SERVICES RVUs: (CPT CODE)

Outpatient Maternal/Fetal E & M/Observation: 1 per hour (CPT 99201-99205)

Common Examples:

1) Cervical ripening
2) Fetal monitoring less than 32 weeks
3) Motor Vehicle Accident
4) IV hydration
5) Labor evaluations

L & D MATERNAL INTENSIVE CARE (MIC) RVUs: (CPT Code)

Admitted inpatients: (Max = 28 RVUs per day) 2/hour (CPT 99291)**

Non-admitted patients (Max = 48 RVUs per day) 2/hour (CPT 99291)

****The maximum MIC RVUs for inpatients is 28 as inpatients shall also be charged the Obstetrics patient day which includes 5 hours of nursing care which is equivalent to 20 RVUs.**

This category is reserved for patients requiring on-going intensive nursing care for time periods specified. Patients may be on inpatient or outpatient status, pre or post delivery. This category may be charged only during the period of intensive interventions. Examples of disease processes with designated pharmaceutical and or nursing interventions are listed below but the examples are not exhaustive.

Diagnoses:

Cardiac Disease
Bleeding Disorders
Pregnancy Induced Hypertension (PIH)
Disseminated Intravascular Coagulation (DIC)
Diabetes Mellitus
Preterm labor
Multisystem Disorders
Asthma

APPENDIX D
STANDARD UNIT OF MEASURE REFERENCES

L & D MATERNAL INTENSIVE CARE (MIC) continued:

In addition to having at least one of the diagnoses identified above, the patient must be receiving at least one of the following intravenous interventions:

Pharmaceutical:

Magnesium Sulfate
Ritodrine
Terbutaline (repeated SQ doses)
Aminophylline
Insulin IV drip
Apresoline
Heparin Sulfate
Phenytoin Sodium (Dilantin)
Nifedipine
Labatalol Drip
AZT drip
IVIG Drip

Nursing Care:

Blood Transfusions (> 2 units)
Nebulizer Therapy
Invasive Hemodynamic Monitoring
Conscious Sedation procedures
- **a) PUBS**
- **b) Fetal surgery**
- **c) Fetal exchange transfusion**

Ventilation Therapy
Labor/Delivery care on another unit