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

EXECUTIVE SESSION
8:30 a.m.

1. **Comfort Order Request - University of Maryland Medical System**
2. **Comfort Order Request - Anne Arundel Medical Center**

PUBLIC SESSION
9:30 a.m.

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**

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

AS OF NOVEBER 30, 2009

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

Docket Number	Hospital Name	Date Docketed	Decision Required by:	Rate Order Must be Issued by:	Purpose	Analyst's Initials	File Status
2050A	University of Maryland Medical System	10/7/09	N/A	N/A	ARM	DNP	OPEN
2051A	Johns Hopkins Health System	10/22/09	N/A	N/A	ARM	DNP	OPEN
2052A	MedStar Health	10/22/09	N/A	N/A	ARM	DNP	OPEN
2053A	Johns Hopkins Health System	11/3/09	N/A	N/A	ARM	DNP	OPEN
2054A	Johns Hopkins Health System	11/3/09	N/A	N/A	ARM	DNP	OPEN
2055R	Dorchester General Hospital	11/30/09	12/29/09	4/29/10	RDL	CO	OPEN

PROCEEDINGS REQUIRING COMMISSION ACTION - NOT ON OPEN DOCKET

None

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: 1860**
BALTIMORE, MARYLAND	*	**PROCEEDING: 2050A**

Staff Recommendation

December 9, 2009

I. INTRODUCTION

The University of Maryland Medical Center ("UMMC," or "the Hospital") filed a renewal application with the HSCRC on October 7, 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 and blood and bone marrow transplant services with United Resource Networks (URN), for a one-year period, effective November 1, 2009.

II. OVERVIEW OF APPLICATION

The contract will 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 regulated services associated with the contract.

III. FEE DEVELOPMENT

The hospital component of the global rates was developed by calculating mean 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. UPI maintains that it has been active in similar types of fixed fee contracts for several years, and that UPI is adequately capitalized to the bear risk of potential losses.

V. STAFF EVALUATION

When the Hospital applied for renewal last year, the experience under this arrangement for the prior year (FY 2008) was slightly unfavorable. At that time, the Hospital took the following actions: 1) negotiated contract improvements including, among other things, an overall rate increase and lower outlier threshold days; 2) a favorable change in the HSCRC's organ acquisition overhead allocation methodology that would result in lower Hospital charges for organ acquisition ; and 3) the initiation of clinical cost-of-care reductions.

The experience under this arrangement in FY 2009, although improved, was still marginally unfavorable. Hospital representatives reported that the new arrangement for FY 2010 included an increase in case rates.

VI. STAFF RECOMMENDATION

After review of the terms of the re-negotiated arrangement and the improved performance in FY 2009, staff recommends that the Commission approve the Hospital's application for an alternative method of rate determination for solid organ and blood and bone marrow transplant services for a one year period retroactive to November 1, 2009.

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 APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION	*	**COMMISSION**	
JOHNS HOPKINS HEALTH	*	**DOCKET:**	**2009**
SYSTEM	*	**FOLIO:**	**1861**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2051A**

Staff Recommendation

December 9, 2009

INTRODUCTION

Johns Hopkins Health System ("System") filed a renewal application with the HSCRC on October 22, 2009 on behalf of the Johns Hopkins Bayview Medical Center (the "Hospital") for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System requests approval from the HSCRC for continued participation in a capitation arrangement serving persons with mental health needs under the program title, "Creative Alternatives (the "Program")." The arrangement is between the Johns Hopkins Health System and the Baltimore Mental Health Systems, Inc., with the services coordinated through the Hospital. The requested approval is for a period of one year.

II. OVERVIEW OF APPLICATION

The parties to the contract include the System and the Baltimore Mental Health Systems, Inc. Creative Alternatives provides a range of support services for persons diagnosed with mental illness and covers medical services delivered through the Hospital. The System will assume the risks under the agreement, and all Maryland hospital services will be paid based on HSCRC rates.

III. STAFF FINDINGS

After several years of favorable performance, staff has found that the experience under this arrangement for FY 2009 was unfavorable. Representatives of the Program attributed the unfavorable performance to added costs associated with the admission of a number of long term patients of State hospitals and several extraordinary expense items incurred in FY 2009, which were beyond the control of the Program. A number of savings and cost cutting measures have been taken, which are projected to produce a favorable performance in FY2010.

IV. STAFF RECOMMENDATION

Based on its overall historically favorable performance and projections of favorable performance in FY 2010, staff recommends that the Commission approve the Hospital's renewal application for an alternative method of rate determination for a one year period commencing November 1, 2009.

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 APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**
DETERMINATION	*	**COMMISSION**
MEDSTAR HEALTH	*	**DOCKET: 2009**
	*	**FOLIO: 1862**
BALTIMORE, MARYLAND	*	**PROCEEDING: 2052A**

Staff Recommendation

December 8, 2009

I. INTRODUCTION

MedStar Health filed an application with the HSCRC on October 22, 2009 on behalf of Union Memorial Hospital (the "Hospital") for an alternative method of rate determination (ARM), pursuant to COMAR 10.37.10.06. MedStar requests approval from the HSCRC for continued participation in a global rate arrangement for orthopedic services with the NFL Player Joint Replacement Benefit Plan (the "NFL Plan") for a one year period beginning December 1, 2009, with an option to seek renewal based upon favorable performance.

II. OVERVIEW OF APPLICATION

The contract will continue to be held and administered by Helix Resources Management, Inc. (HRMI). HRMI 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 was developed by calculating the mean historical charges for all patients receiving the procedures for which global rates are to be paid. The negotiated rates are comparable to another joint replacement ARM already approved by the HSCRC. The NFL Plan agreement includes only joint replacements and not the more costly revisions of prior joint replacements for the same joint. In addition, the agreement does not include the post-acute rehabilitation normally included in joint replacement global pricing. The remainder of the global rate is comprised of physician service costs.

IV. IDENTIFICATION AND ASSESSMENT OF RISK

The Hospital will continue to submit bills to HRMI for all contracted and covered services. HRMI 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 HRMI and the Hospital holds the Hospital harmless from any shortfalls in payment from the global price contract.

V. STAFF EVALUATION

The staff reviewed the methods employed to develop the hospital component of the proposed rates and believes that the hospital component of the global rate is reasonably related to historical experience. Staff has noted that the NFL Plan agreement has a more narrow definition of the episode of care covered under the global rates than other similar ARM arrangements. In addition, staff found that the Hospital and HRMI have a favorable history of managing joint replacement patients and performing under a global rate arrangement. The physicians' professional components of the proposed rates follow historical fee for service averages and are closely related to the professional components of the Hospital's similar global arrangement involving orthopedic surgery.

VI. STAFF RECOMMENDATION

Although there has been no activity, staff still believes that the Hospital can achieve favorable performance under this arrangement. Therefore, staff recommends that the Commission approve the Hospital's request for continued participation in the alternative method of rate determination for orthopedic services for a one year period, commencing December 1, 2009. The Hospital will need to file a renewal application for review to be considered for continued participation.

Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the 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 APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION	*	**COMMISSION**	
JOHNS HOPKINS HEALTH	*	**DOCKET:**	**2009**
SYSTEM	*	**FOLIO:**	**1863**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2053A**

Staff Recommendation

December 9, 2009

I. INTRODUCTION

Johns Hopkins Health System ("the System") filed a renewal application with the HSCRC on November 3, 2009 on behalf of its member hospitals, the Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, and Howard County General Hospital (the "Hospitals") for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System requests approval from the HSCRC for continued participation in a capitation arrangement serving persons insured with Tricare. The arrangement involves the Johns Hopkins Medical Services Corporation and Johns Hopkins Healthcare as providers for Tricare patients. The requested approval is for a period of one year.

II. OVERVIEW OF APPLICATION

The parties to the contract include the Johns Hopkins Medical Services Corporation and Johns Hopkins Healthcare. The program provides a range of health care services for persons insured under Tricare including inpatient and outpatient hospital services. Johns Hopkins Health Care will assume the risk under the agreement, and all Maryland hospital services will be paid based on HSCRC rates.

III. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' renewal application for an alternative method of rate determination for a one year period beginning January 1, 2010. This recommendation is based on both historical favorable contract performance and projections.

Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospitals for the approved contract. This document would formalize the understanding between the Commission and the Hospitals, and would include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and

annual reporting, confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract, The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rtae increases.

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION	*	**COMMISSION**	
JOHNS HOPKINS HEALTH	*	**DOCKET:**	**2009**
SYSTEM	*	**FOLIO:**	**1864**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2054A**

Staff Recommendation

December 9, 2009

I. INTRODUCTION

Johns Hopkins Health System (“the System”) filed a renewal application with the HSCRC on November 17, 2009 on behalf of its member hospitals, Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, and Howard County General Hospital (the “Hospitals”) for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System requests approval from the HSCRC to continue to participate in a global rate arrangement for solid organ and bone marrow transplants with Coventry Transplant Network for a period of three years.

II. OVERVIEW OF APPLICATION

The contract will be continue to be held and administered by Johns Hopkins HealthCare, LLC ("JHHC"), which is a subsidiary of the System. JHHC will manage all financial transactions related to the global price contract including payments to the System hospitals and bear all risk relating to regulated services associated with the contract.

III. FEE DEVELOPMENT

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

IV. IDENTIFICATION AND ASSESSMENT OF RISK

The Hospitals will continue to submit bills to JHHC for all contracted and covered services. JHHC is responsible for billing the payer, collecting payments, disbursing payments to the Hospitals at their HSCRC approved rates, and reimbursing the physicians. The System contends that the arrangement among JHHC, the Hospitals, and

the physicians holds the Hospitals harmless from any shortfalls in payment from the global price contract. JHHC maintains that it has been active in similar types of fixed fee contracts for several years, and that JHHC is adequately capitalized to bear risk of potential losses.

V. STAFF EVALUATION

Based on the favorable performance in the last year, staff believes that the Hospitals can continue to achieve a favorable experience under this arrangement.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for solid organ and bone marrow transplant services, for a one year period commencing December 1, 2009. The Hospitals will need to file a renewal application for review to be considered for continued participation.

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

IN RE: THE PARTIAL RATE	*	**BEFORE THE HEALTH SERVICES**	
APPLICATION OF	*	**COST REVIEW COMMISSION**	
DORCHESTER GENERAL	*	**DOCKET:**	**2009**
HOSPITAL	*	**FOLIO:**	**1865**
CAMBRIDGE, MARYLAND	*	**PROCEEDING:**	**2055R**

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Staff Recommendation

December 9, 2009

Introduction

On November 24, 2009, Dorchester General Hospital (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 December 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 December 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 $1,307.11 per treatment, while the statewide median rate for RDL services is $638.29 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 $638.29 per treatment be approved effective December 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.

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

December 9, 2009

This is a final recommendation and is ready for action by the Commission.

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

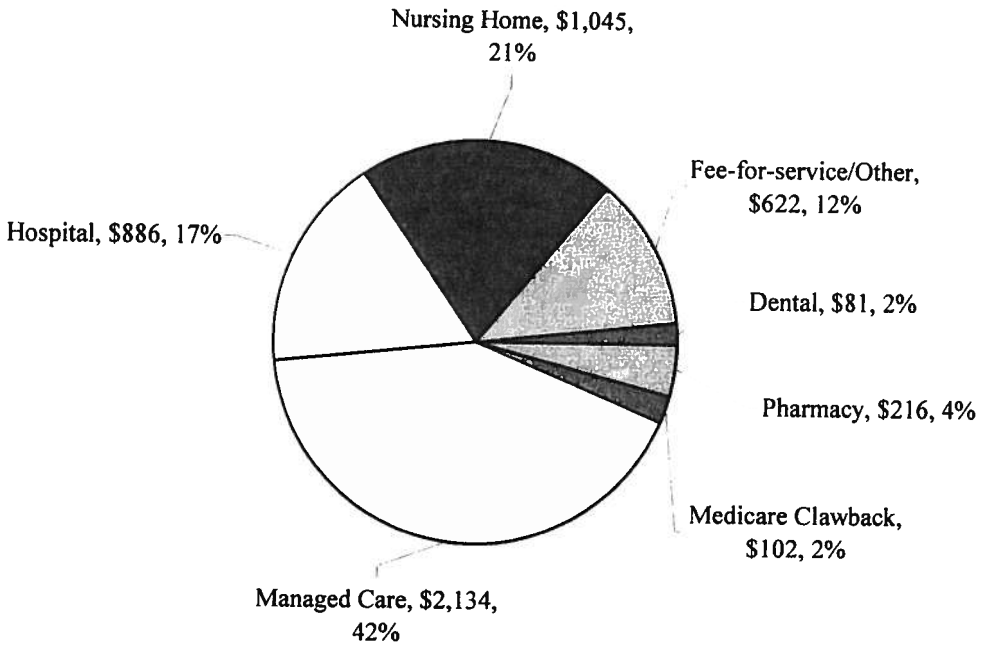
		Estimated Annualized Hospital Revenue	Hospital Portion of BPW Cuts	Medicaid Feedback Effect	Supplemental Budget Cuts	Total Hospital Portion	Payer Portion of BPW Cuts	Medicaid Feedback Effect	Total Payer Portion
210001	Washington County Hospital	$249,540,192	$334,074	$10,189	$192,497	$536,761	$334,074	$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. Center	$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 Cent	$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

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%		

Draft Staff Recommendation on Rate Methods and Financial Incentives relating to Short Stay Cases in the Maryland Hospital Industry

Health Services Cost Review Commission
December 9, 2009

This document represents a draft recommendation to be presented to the Commission on December 9, 2009. Comments on this recommendation should be directed to Robert Murray, Executive Director of the HSCRC, by Wednesday, January 6, 2010.

Introduction

This recommendation relates to recommended changes in rate incentives associated with so-called one-day length of stay ("one-day LOS ") cases reimbursed through the Maryland rate setting system. This document also recommends modifications to the calculation of hospital Charge per Case (CPC) constraints to appropriately account for denied cases in the establishing of approved revenue.

For purposes of this recommendation, one-day length of stay acute care cases are defined as cases that are admitted to an acute inpatient unit and have either a zero or one-day length of stay. Denied cases refer to patients who were originally admitted to an inpatient unit, but after additional review (and any associated hospital appeal) it was determined that the decision to admit was not medically necessary. Denied cases may have length of stay of zero days, one day or more than one day.

Background

Basis for this Review and Recommendation

This issue is currently a focus of discussions between both HSCRC staff and industry representatives due to developments both nationally and internal to Maryland:

1) One-day length of stay cases have recently been a focus of the national Medicare Recovery Audit Contractor ("RAC") initiative currently authorized by federal law to identify areas of both overpayment and underpayment to acute care hospitals by the Medicare program. The RAC process was initially piloted in several states but will be expanded to all states (including Maryland) by January 2010. One-day LOS cases have been a particular area of focus for the RAC because of concern regarding whether or not these admissions meet Medicare's medical necessity criteria. In RAC audits in pilot states, large numbers of one day LOS cases were denied based on RAC determinations that the cases should not have been admitted for inpatient care because they were appropriate for outpatient observation (OBS) or other less-intensive (and less costly – from Medicare's perspective) forms of care. One-day LOS cases for chest pain patients are an example of a condition targeted by RACs;

2) Recently, several private payers (likely in reaction to the focus on one-day stays by Medicare nationally), contacted the HSCRC staff regarding the wide variation in the use of outpatient observation services by Maryland hospitals. These private payers believed that Maryland hospital practices were leading to an overuse of inpatient levels of care for patients that could be treated as observation cases. Overuse of inpatient services for cases that could be treated on an outpatient observation basis results in excess medical cost and potential additional clinical risks for patients (exposure to generally higher rates of complications for inpatient cases than for outpatient cases).

3) Additionally, in recent months, staff became aware of what it believes is inaccurate reporting of denied (based on medical necessity criteria) inpatient cases. This issue and the associated

hospital reimbursement implications will also be discussed and addressed in the staff's recommendations for changes to HSCRC payment policies.

These three developments caused the HSCRC to analyze Maryland hospital performance on one-day LOS cases, both over time and relative to hospitals in other states. This recommendation will discuss the results of this analysis and provide recommendations for changes to HSCRC payment policy based on what HSCRC staff believes to be excessive financial incentives to admit many of these cases.

Dynamics of One-Day Stays in Maryland and Related Implications

Historically, Maryland hospitals have admitted a higher percentage of one-day cases (as a proportion of total inpatient admission) relative to hospitals nationally. **Table 1** provides a comparison of proportions of one-day LOS admissions as a percentage of state-wide admissions for the years 2003 – 2008 for both all-payers and for Medicare. The table shows Maryland admits 6% more one-day stays overall and 4% more Medicare one-day stay cases than hospitals in the rest of the US.

Table 1

Maryland Proportion of 1 Day LOS Cases
as a % of Total Statewide Cases

	2003	2004	2005	2006	2007	2008
Maryland Medicare Cases	16.58%	16.99%	17.54%	17.83%	17.59%	17.49%
US Medicare Cases	13.30%	13.44%	13.48%	13.75%	13.68%	13.40%
Difference	3.28%	3.55%	4.06%	4.08%	3.91%	4.09%
Maryland All-Payer (excluding newborns)				22.48%		
US All-Payer (estimateHCUP data excluding newborns)				16.58%		
Difference				5.90%		
Maryland (All Payer)						21.40%
New York State (All Payer data)						15.30%
						6.10%

This difference in admitting practices also does not appear to be regional a phenomenon. **Table 2** shows that Maryland hospitals also admit much higher proportions of one-day LOS cases than do hospitals in neighboring areas.

Table 2

Maryland Proportion of 1 Day LOS Cases as a % of Total Statewide Cases (Medicare) - Region (2007)			
	Total Cases	1 Day Cases	Proportion
Maryland	255,153	45,013	17.60%
Washington DC	36,053	4,548	12.61%
Delaware	40,701	4,733	11.63%
Pennsylvania	559,799	69,507	12.42%
Virginia	285,149	36,001	12.63%

The comparisons of Maryland hospital performance on one-day LOS cases versus hospitals nationally is further substantiated by data provided by a national private insurer, United Health Care. According to United's national data, Maryland has the second highest use of inpatient hospitalization in the country, for cases that met United's criteria for treatment on an observation basis. The Maryland percentage is 62% compared to the average of United's national case totals of 36%.

These results and other information (assembled by staff) reveal a tendency for Maryland hospitals to admit patients rather than treat them on an outpatient basis. Staff believes that treating patients on an outpatient observation basis will be both less costly to the paying public (from a payment standpoint) and arguably less-risky (from a quality of care standpoint) setting.

In light of these findings, staff began to examine whether the financial incentives in the Maryland hospital payment system somehow contributed to this excessive tendency to admit one-day LOS cases. Staff believes that the potential for generating so-called "rate-capacity" on denied and non-denied one-day cases does indeed create too strong of a financial incentive for Maryland hospitals to admit short stay (most predominantly one-day LOS cases).

Creation of "Rate Capacity" on One-day LOS Cases and Denied Cases

Under the HSCRC payment system, hospitals are paid at discharge on a fee-for-service basis for all facility-related charges. Thus, the payment received by the hospital for any given allowed case will be a function of the HSCRC-approved unit rates times the units of service by rate center for that case. **Figure 1** is an example of a sample bill (and payment) for a hypothetical one-day LOS case. Based on the resources used by this patient, the hospital will be paid approximately $5,100 for this case at the time of discharge. However, because this case was ultimately assigned to a Diagnostic Related Group ("DRG")

that on average had charges of $7,700 per case, the hospital gets "credit" for this average level of charging. This credit is factored in during the year when the HSCRC staff determines the hospital's overall CPC constraint and "approved revenue" (i.e., what amount of revenue the hospital charged patients during the year that it ultimately gets to keep).

Figure 1

Example of a Hospital Bill for a One-Day LOS Cases

Rate Center	Approved Rate		Units of Service		
Emergency Room	$35.00	X	15 RVUs	=	$525
Admission Charge	$175.00	X	1 Per Pt.	=	$175
Medical Surgical Unit	$1,000.00	X	1 Day	=	$1,000
Laboratory	$7.50	X	52 RVU	=	$390
Blood	114	X	5 CAPS	=	$570
Radiology Diagnostic	$18.00	X	15 RVU	=	$270
Supplies	$1,700.00	X	1 Per Pt.	=	$1,520
Drugs	$950.00	X	1 Per Pt.	=	$650
Total Bill (Payments to hospital for this case)					$5,100

Note: case assigned to DRG 100 which carries an average DRG weight of 0.77 if the average Maryland hospital case (index of 1.0) has a charge of $10,000, this hospital ultimately gets DRG "credit" of 0.77 x $10,000 = $7,700.

In this circumstance, although the hospital received payments of $5,100 for the short-stay case, it simultaneously generates the ability to raise its rates to all payers by an additional $2,600 (the difference between the average DRG weight or credit and the actual payment for the specific one-day LOS case) and then receive this additional revenue during the course of the year through higher unit rates charged to all payers. This additional revenue is referred to as "rate capacity." Hospitals, thus, have a very strong incentive to admit short-stay cases in the Maryland system and the data provided shows that Maryland hospitals have been responding aggressively (relative to hospitals in other states) to this incentive.[1]

The concept of "rate capacity" also applies to the denied case issue as well. Hospital that inaccurately report denied cases to the HSCRC on their monthly revenue and volume reports receive full "rate capacity" for these cases, when, in fact, the denying payer (or the self-denying hospital) has determined the case was not appropriately classified as an inpatient case. Cases that are not inpatient cases are not eligible for inclusion in the HSCRC's CPC methodology and, therefore, should not generate any rate capacity for that hospital.

[1] Staff would note that while hospitals in other states have a similar incentive under Medicare's per case payment system, Maryland hospitals face this very strong incentive to admit short-stay cases for all of their cases. The ability to generate "rate capacity" across all of their patients may be the primary reason for the aggressive response in the State.

Implications of Rate Capacity on Excessive One-Day Stays and Denied Cases

The implications of these two circumstances related to the issue of "rate capacity" are that: 1) for denied admissions, all payers are made to pay for cases that were deemed medically unnecessary and denied as an inpatient case (as shown above); and 2) for one-day stay cases, Maryland hospitals have generated extra payments and windfall rewards for admitting a large proportion of patients that could otherwise be treated on an outpatient basis (as is the case in other states). Although the actual treatment costs (expenses incurred by the hospital) for one-day stay patients are alleged by hospital representatives to be the same in either setting, admitting these patients triggers inpatient payments that are in effect 50-60% higher than the same care in an observation/outpatient setting. Thus, Maryland hospitals have had little incentive to establish an outpatient observation service, when the use of such a service is quite common nationally.[2]

Rate Capacity Generated on One-Day LOS Cases: the Crux of the Issue

This extra inpatient revenue (or additional rate capacity) is at the crux of the one-day LOS case issue. It is also the basis for the disagreement between staff and the hospital industry on how to best revise the incentives that drive this behavior.

As noted, the opportunity to generate these extra amounts provides the strong incentive for Maryland hospitals to admit larger proportions of short-stay patients than their counterparts in the rest of the nation. Secondly, the hospital industry argues that it should be allowed to keep this extra rate capacity and revenue because they are associated with costs that have always been part of the system (the status quo). Conversely, the staff believes this extra rate capacity provides too strong an incentive to admit, and it contributes to higher than necessary charges to the public.

Staff further believes that the generation of relatively easy, windfall profits on short-stay cases may contribute to inefficiency more broadly across hospital operations. First, this extra rate capacity appears to be a primary reason why most Maryland hospitals have deliberately not developed more cost-effective (from a payer perspective) observation services. Second, the availability of relatively easy rewards on short-stay cases may well enable less efficient management of cases with longer lengths of stay (the so-called "loser" cases). The past 35 years of rate setting experience in Maryland has been demonstrative of the fact that the level of revenues in the system drives hospitals expenses and levels of relative efficiency. This observation is also strongly supported by the Medicare Prospective Payment

[2] Average payment weights developed for the HSCRC's planned Charge per Visit Outpatient constraint system show that outpatient observation cases may generate a payment of between $4,500 – 5,000 per case compared to the approximate $7,700 overall revenue credit generated for that same case if admitted to an inpatient service. This is comparable to the average charges generated by hospitals when one-day LOS cases are admitted to an inpatient unit. The majority of these charges are related to ancillary testing performed on these patients. Thus, while the actual cost to the hospital for providing care to these patients may be similar regardless of the treatment setting, the decision to admit the patient generates on average $2,600 additional payments for hospitals or $2,600 extra costs to the paying public.

Commission (MedPAC) who, in March of 2009, documented this relationship in their report to Congress.[3]

The hospitals' perception is the reverse however - - that costs are largely exogenous (given or unable to be influenced) and, therefore what they expend on patient care should in turn drive system revenues. In other words, the status quo level of cost in the system mandates that associated revenues should be retained by the industry.

Staff disagrees conceptually with this assertion based on the HSCRC experience in observing the relationships between system revenues and system costs over time. More importantly, in the current financial and budgetary environment, the status quo cannot and should not be preserved.

Maryland Vulnerabilities

Hospitals nationally operating under Medicare Inpatient Prospective Payment System ("IPPS") are paid on an average DRG-based per case payment basis. The payment they receive per case is a function of the particular DRG each patient is assigned to. Patient assignment to DRGs depends on the particular primary and secondary diagnoses codes abstracted from each patient's medical record. DRG per case payment amounts reflect the average costs of all cases assigned to a DRG. Thus, hospitals nationally face similar incentives to aggressively admit – but only for payers that use per case DRG-based payment, such as Medicare.

The Centers for Medicare and Medicaid Services (CMS) instructed its RAC auditors to focus on short-stay cases because it presumed that some hospitals nationally have also been responding too aggressively to the financial incentives to admit under IPPS. In general, the RAC activities nationally, authorized in the Tax Relief and Health Care Act of 2006, are an attempt by Congress to "indentify improper Medicare payments and fight fraud, waste and abuse in the Medicare program." The perception that there remains considerable waste and inefficiency in the US health care system is a sentiment shared by the White House today, which also believes that significant improvements in inefficiency can be achieved by specifically targeting areas of waste and excess payments.

The RAC audits and review will cover multiple areas but are geared to explicitly target one-day LOS cases across the country. The State of Maryland is particularly vulnerable because of the high levels of one-day stays overall and the State's high proportion of one-day stay cases in specific DRGs that have been the subject of RAC focus in other states. **Table 3** shows DRGs with the highest proportion of total cases that are one-day stay cases in Maryland. The table also compares Maryland's proportion of select DRGs that are one-day stays with the proportion of cases by DRG that are one-day stays for the rest of the nation.

[3] MedPAC report to Congress, March 2009. Pages 67-71.

Table 3

Percent One Day Length of Stay by DRG
Maryland Hospitals 2009

APR DRG	APG Description	Total Cases	One Day Stay Cases	% One Day Stay Cases	National %
	All	620,102	140,673	23%	
203	CHEST PAIN	13,384	9,884	74%	44%
175	PERCUTANEOUS CARDIOVASCULAR PROCEDURES	9,534	6,890	72%	44%
198	ANGINA PECTORIS & CORONARY ATHEROSCLEROS	9,577	5,674	59%	30%
201	CARDIAC ARRHYTHMIA & CONDUCTION DISORDER	10,132	3,605	36%	28%
204	SYNCOPE & COLLAPSE	8,078	3,166	39%	22%
225	APPENDECTOMY	5,358	2,953	55%	
249	NON-BACTERIAL GASTROENTERITIS, NAUSEA & VO	8,005	2,888	36%	
243	OTHER ESOPHAGEAL DISORDERS	4,483	2,726	61%	
513	UTERINE & ADNEXA PROCEDURES FOR NON-MALIG	5,315	2,189	41%	
140	CHRONIC OBSTRUCTIVE PULMONARY DISEASE	15,134	2,181	14%	10%
310	INTERVERTEBRAL DISC EXCISION & DECOMPRESSIO	3,939	2,153	55%	
141	ASTHMA	5,685	2,141	38%	
194	HEART FAILURE	18,921	2,140	11%	12%
139	OTHER PNEUMONIA	14,699	2,048	14%	
321	CERVICAL SPINAL FUSION & OTHER BACK/NECK PR	3,558	2,040	57%	
192	CARDIAC CATHETERIZATION FOR ISCHEMIC HEART	4,010	1,986	50%	
47	TRANSIENT ISCHEMIA	5,361	1,944	36%	21%
566	OTHER ANTEPARTUM DIAGNOSES	4,648	1,937	42%	
383	CELLULITIS & OTHER BACTERIAL SKIN INFECTIONS	11,684	1,830	16%	
254	OTHER DIGESTIVE SYSTEM DIAGNOSES	5,991	1,738	29%	
420	DIABETES	6,360	1,585	25%	
663	OTHER ANEMIA & DISORDERS OF BLOOD & BLOOD-	4,708	1,577	33%	
173	OTHER VASCULAR PROCEDURES	4,999	1,564	31%	
24	EXTRACRANIAL VASCULAR PROCEDURES	2,341	1,563	67%	65%
53	SEIZURE	5,614	1,447	26%	
144	RESPIRATORY SIGNS, SYMPTOMS & MINOR DIAGNO	3,375	1,383	41%	
199	HYPERTENSION	2,944	1,343	46%	
463	KIDNEY & URINARY TRACT INFECTIONS	9,753	1,303	13%	8%
404	THYROID, PARATHYROID & THYROGLOSSAL PROCE	1,509	1,272	84%	

In the "chest pain" DRG for instance, 44% of all admissions for chest pain nationally are one-day LOS cases. In Maryland, 74% of all cases admitted for chest pain are one-day cases. **Table 4** is the results of an analysis of McBee and Associates, a local management consulting company, estimating Maryland hospital potential exposure to RAC denials of one-day LOS cases in RAC targeted DRGs.

Table 4

Targeted RAC DRGs (source McBee Associates Inc.)

	Admissions	1 Day Stays	% of 1 Day Stays	Potential RAC Loss
Maryland	**109,651**	**18,726**	**17.08%**	**($41,703,401)**
Washington DC	13,084	1,223	9.35%	($7,388,503)
Delaware	16,404	1,558	9.50%	($6,633,195)
Pennsylvania	232,956	24,649	10.58%	($98,254,117)
Virginia	122,956	14,182	11.53%	($51,996,991)

CMS recently reported that the RACs had succeeded in correcting more than $1.03 billion in Medicare improper payments in the five pilot states. Approximately 96 percent ($992.7 million) of the improper payments were overpayments collected from providers, while the remaining 4 percent ($37.8 million) were underpayments repaid to providers. RAC audits of Maryland hospitals are expected to commence after January of 2010. In the pilot states, hospitals routinely appealed RAC auditor determinations which resulted in considerable expenditure on the part of providers on legal and consulting services since implementation of the RAC program in 2006.

Inevitably, Maryland hospital relatively unfavorable performance on one-day LOS cases will likely be a focus of future RAC audit activity. As noted above, the HSCRC staff believes that the HSCRC can more appropriately address this issue through a systematic change to the incentives in the rate setting system. Staff would also seek to convince CMS of the value of implementing a more systematic approach to reducing one-day stays in the State. Discussions with CMS personnel are on-going. Staff's success in convincing the federal agency to divert its attention away from the one-day LOS issue, however, is highly dependent on the ultimate action taken by the Commission on this issue.

The Handling of Denied Cases in the HSCRC's Charge per Case (CPC) Methodology

During its review of Maryland hospital one-day LOS performance, staff also became aware of an inaccuracy in the way in which most hospitals are reporting denied admissions (a majority of which are likely one-day stay cases) to the HSCRC. When an inpatient case (either a one-day stay or longer LOS case) is denied for payment purposes, hospitals are not paid for services rendered and must account for the denied payments as a contractual allowance. In some circumstances, hospitals have the ability to self-disallow one-day cases, in the expectation that payers will not pay for these cases on an inpatient basis.[4] These cases by definition are not inpatient services, and the charges associated with these cases

[4] Per Medicare conditions of participation, acute care hospitals must initiate a utilization review (UR) infrastructure that provides for review of services furnished by that hospital and medical staff for Medicare patients. A UR review committee must be established by the hospital to carry out UR review for Medicare patients. The UR infrastructure must provide for review of Medicare and Medicaid patients with respect to the medical necessity of:1) admission to the institution; 2) duration of stays; and 3) professional services furnished. If a particular case does not meet Medicare criteria for medical necessity, the UR committee may in effect self-deny that case. The hospital will then not receive payment for inpatient services rendered on that case.

should not be reported to the HSCRC as inpatient revenue, eligible for the Commission's CPC methodology.

It appears, however, that many hospitals have inappropriately been including these cases in the data they report to the HSCRC for the calculation of the hospitals' approved CPC. As noted, the inaccurate reporting of these denied cases as inpatient admissions inappropriately generates full "DRG- weight" credit for the denied cases. This DRG-weight credit gives the hospitals the ability to improperly raise their unit rates to all other payers to generate the disallowed revenue associated with their denied cases.

Based on this dynamic, the HSCRC staff requested that hospitals provide a report of denied cases for FY 2009. Although staff has concerns about the accuracy and consistency of reporting by hospitals in this preliminary 2009 report, it does appear that approximately 4,000-5,000 cases were denied (either by payers or self-disallowed by hospitals on an annualized basis). **Table 5** provides a summary by hospital for the first 9 months of FY 2009. Staff estimates that the improper reporting of these denied cases in the monthly HSCRC data resulted in unintentional rate capacity in excess of $30-$40 million for rate year 2009.

Table 5

Denied Admissions Summary
Nine Months Data FY 2009

	Reported Denied Admissions	Total Charges	Charge Per Case
WASHINGTON COUNTY	19	$78,851	$4,150
UNIVERSITY OF MD.	85	$422,608	$4,972
PRINCE GEORGE'S	38	$253,361	$6,667
HOLY CROSS	34	$184,303	$5,421
FREDERICK MEMORIAL	66	$319,480	$4,841
HARFORD MEMORIAL	20	$75,510	$3,776
SAINT JOSEPHS	72	$423,620	$5,884
MERCY	136	$501,518	$3,688
JOHNS HOPKINS	133	$960,850	$7,224
DORCHESTER GENERAL	3	$14,050	$4,683
SAINT ANGES	295	$1,644,443	$5,574
SINAI	73	$528,899	$7,245
BON SECOURS	3	$16,813	$5,604
FRANKLIN SQUARE	88	$360,723	$4,099
WASHINGTON ADVENTIST	8	$34,220	$4,278
GARRETT COUNTY	27	$86,855	$3,217
MONTGOMERY GENERAL	80	$400,571	$5,007
PENINSULA REGIONAL	78	$468,681	$6,009
SUBURBAN	132	$1,086,667	$8,232
ANNE ARUNDEL	212	$973,827	$4,594
UNION MEMORIAL	15	$122,830	$8,189
MEMORIAL AT CUMBERLAND	5	$24,073	$4,815
Braddock	4	$28,664	$7,166
SAINT MARY'S	38	$350,446	$9,222
JOHNS HOPKINS / BAYVEIW	295	$1,634,857	$5,542
CHESTER RIVER	29	$130,710	$4,507
UNION OF CECIL	109	$372,721	$3,419
CARROLL COUNTY	362	$1,131,852	$3,127
HARBOR HOSPITAL CTR.	50	$203,880	$4,078
CIVISTA	35	$71,337	$2,038
MEMORIAL AT EASTON	18	$82,320	$4,573
MARYLAND GENERAL	73	$448,075	$6,138
CALVERT MEMORIAL	102	$411,920	$4,038
NORTHWEST HOSPITAL	49	$190,176	$3,881
BALTIMORE WASHINGTON	51	$306,584	$6,011
G.B.M.C	22	$166,498	$7,568
Mc CREADY	2	$11,185	$5,593
HOWARD COUNTY	45	$223,604	$4,969
UPPER CHESAPEAKE	30	$96,566	$3,219
DOCTORS	35	$403,882	$11,539
SOUTHERN MARYLAND	54	$219,308	$4,061
GREATER LAUREL	18	$112,124	$6,229
FORT WASHINGTON	4	$22,399	$5,600
ATLANTIC GENERAL	2	$10,261	$5,131
KERNAN	0	$0	NA
GOOD SAMARITAN	30	$182,687	$6,090
SHADY GROVE ADVENTIST	6	$23,405	$3,901
UNIVERSITY SPECIALTY	0	$0	NA
UNIVERSITY OF MD. MEIMS	0	$0	NA
UNIVERSITY OF MD. CANCER (	0	$0	NA
Totals	3,085	$15,818,214	$5,127
		Estimate of Permanent Rev. Removed FY 2010	Approximate DRG weight for 1 day Cases
Annualized Total	4,113	$30,850,000	$7,500

This denied case report is now a mandated report by the HSCRC. First quarter of FY 2010 is due in the first week of December 2009. The HSCRC will receive quarterly reports on all denied cases for each subsequent quarter.

Discussions with Payer and Hospital Representatives

In recent weeks the HSCRC staff formed a One Day LOS and Denied Case Workgroup, consisting of representatives from HSCRC staff and the hospital and payer industries. During those discussions the staff presented its findings and observations regarding both the one-day LOS and the denied case issues. The staff also presented its proposals for modifications to the HSCRC's CPC constraint system to provide more appropriate incentives for hospitals treatment of short-stay cases and for elimination of denied cases from the HSCRC's CPC methodology. The discussions of this workgroup focused on the proposed adjustments for one-day LOS cases in the Maryland Rate Setting System. A presentation describing the Maryland Hospital Association position on both the staff proposed one-day LOS and denied case recommendations was distributed and discussed and is included in **Appendix I** of this recommendation. The payer industry representatives have voiced support for the staff recommendation.

In general, the MHA has articulated the following position on the staff recommendation:

1 – MHA strongly opposes the staff proposal for the application of an incentive (penalty) for hospitals fail to shift one-day cases that can appropriately be treated in an outpatient and observation unit.

2 – The hospital industry and the MHA recognize that the HSCRC rate system is a system of averages. Cases of differing lengths of stay are grouped into various diagnostic categories (Diagnostic Related Groups or DRGs). For each DRG category, there will be cases assigned to that category that have lengths of stay that are shorter or longer than the average of all cases in that category. Thus, for each hospital, there are "winner" cases (those with length of stay below the average case) and "loser" cases, (those with length of stay that are longer than the average case in that category). For instance, for a DRG category like chest pain – the average length of stay for chest pain may be 3.5 days. Cases that stay shorter than 3.5 days are "winner" cases – that is they generate rewards or rate capacity and those that stay longer are likewise "loser" cases (the hospital generates a loss relative to the average level of reimbursement).

3 – MHA argues that any adjustment must be revenue neutral (i.e., retain all rate capacity generated by one-day stays as part of the inpatient revenue base – that is spread these surplus revenues back across all remaining inpatient cases) with no change in their payment levels or approved revenue.

4 – The hospital industry also recommends a restructuring of HSCRC outpatient rate setting centers prior to the implementation of any policy change that encourages hospitals to appropriately shift cases to observation status.

5 – The MHA advanced two proposals for encouraging hospitals to shift one-day stay cases to observation. One treats all one-day stay cases as "categorical exclusions" (not part of the HSCRC's CPC system and paid only on the basis of charges). The second option is for a modification of the "case weight" associated with one-day stays.

6 – With regard to denied cases, the MHA agrees with staff that these cases should eliminated from the CPC however, the industry wishes to retain all historical revenues associated with the past reporting of denied cases in their inpatient base revenue.

Staff Observations Regarding One-day LOS Cases and Hospital Behavior

1-While Hospitals nationally have increasingly been treating Short-stay Patients in Lower "Cost" (cost to payers) Outpatient Settings – Maryland Hospitals Have Not.

Based on the evidence shown, and based on staff's review of the dynamics of the HSCRC's current CPC payment methodology, while hospitals nationally have been shifting the treatment for short-stay cases to outpatient settings, it appears that Maryland hospitals have been responding to the very strong payment incentives to continue to admit short stay cases rather than treat them on an outpatient basis (when deemed medically appropriate to do so). Thus, while hospitals nationally have lowered the overall cost of hospital care to payers by treating short-stay patients in a more efficient fashion, Maryland hospitals lag behind the US on this dimension of care. This perception is supported by various payer representatives in the Maryland system based on their experience nationally. The differences in the proportions of admitted patients that are one-day stays (in Maryland vs. the US) have been noted previously, and these differences are dramatic.

2- The Key issue Here Centers on the Generated "Rate Capacity" by Maryland Hospitals.

As noted, the crux of this issue is the extra rate capacity available to Maryland hospitals associated with short-stay cases. It provides that very strong incentive to admit, and it has dissuaded hospitals from establishing observation units and shift these one-day LOS cases to outpatient care. As shown in the example in Figure 1 above, for every one-day case admitted to an inpatient unit, hospitals generate both actual payments of $5,100 on average, and additional rate capacity of approximately $2,600 per case on average. Total surplus rate capacity on all one-day stay cases is in excess of $300 million per year. When a hospital decides to observe patients (rather than admit them) the paying public avoids that extra $2,600 premium payment and the hospital foregoes that extra rate capacity. Thus, in the most recent year, only a few hospitals in Maryland have moved in the direction of establishing observation units (likely in response to the threat of RAC related audits later this year). In the absence of some additional incentive, most hospitals in the State will continue to admit one-day stay cases that could appropriately and more effectively be treated on an observation basis.

3 – The Existence of Excess Rate Capacity for a large proportion of One-day Cases Results in Unnecessary Higher Payments by the Paying Public and Contributes to Continued Inefficiency in the Hospital Industry.

Hospitals correctly say that the HSCRC rate system is a system of averages – cases that are easier to manage generate surpluses for hospitals and are so-called "winners" for hospitals, while some cases are more difficult to manage (and have lengths of stay longer than the average). These cases generate loses (hospital expenses exceed reimbursements), and these are referred to by the industry as "losers." According to the MHA, the much higher proportion of one-day LOS cases in Maryland (relative to the standard of practice nationally) are "required" to balance out all the other "loser" cases in the system.

Conversely, staff believes that one-day stay cases that could otherwise be appropriately cared for on a less costly (to the public) observation basis should not be categorized as "winner" cases in the sense that they are very different from other inpatient cases that need to be actively managed (manage ancillary use and length of stay) to ensure the hospital is operating efficiently and effectively. One-day cases that could rightfully be observation cases are by definition not heavily managed relative to other inpatient cases. The primary management decision associated with such a case is whether hospital management has made the decision whether to offer an Observation service or not. Staff finds that most hospitals refusal to provide an Observation service forces clinicians to admit excessive numbers of one-day stay

cases. And under the current system, this is not a difficult decision. The decision to admit a one-day stay case generates an automatic $2,600 extra payment for each case on average.

It is clear that Maryland hospitals make this "admit" decision far too frequently – both because of the presence of this excessive reward and based on a review of practice standards nationally where hospitals admit a far smaller proportion of one-day stay cases and provide the same care more efficiently to the public. The admission of too many of these observation-eligible cases in Maryland also dilutes the incentive of hospitals to manage their other cases more aggressively and turn "loser" cases into "winner" cases. This argument is consistent with the staff and MedPAC's observations that the level of revenues in the system drives cost performance. Thus, staff believes these observation-eligible cases should not be viewed as "winner" cases necessary to offset the less than efficient management of other cases on the inpatient service. Rather, they should be viewed as cases that present the system with an opportunity to generate higher levels of efficiency and reduce the cost of hospital care.

Less Favorable Comparison to the Nation on the HSCRC's Net Patient Revenue per Case Measure

Additionally, the presence of such a high proportion of these observation-eligible cases as inpatient admissions serves to artificially reduce Maryland's average net patient revenue (NPR) per case vs. the nation. The NPR per case (Maryland vs. the US) has been used as the basis of comparing whether the rate system here is delivering any additional value in terms of lower payments to Maryland citizens relative to what exists elsewhere. In recent years Maryland's NPR per case has been nearly at the US average NPR per case (having eroded from a position of 4% below the US average. Had Maryland more appropriately shifted observation-eligible one-day stay cases to outpatient, the State would have had a NPR much higher than the US average NPR per case. Thus, staff believes that observation-eligible one-day stay cases artificially improve Maryland's position vs. the US on payments per case (and on the Medicare Waiver test), but the higher proportions of these cases in Maryland are not indicative of more efficient operation.

4 - Denied Cases are by Definition not Eligible for the HSCRC's CPC and by Including these Cases in Monthly Revenue and Volume Data Hospitals have been Submitting Substantially Inaccurate Reports to the HSCRC.

Maryland hospitals have been erroneously and inaccurately submitting monthly revenue and volume reports to the HSCRC. These reports are the basis for determining each hospital's Charge per Case constraint and ultimately their overall approved inpatient revenue. Submission of cases that were denied payment (based on a finding of medical necessity) represents inaccurate reporting on the part of Maryland hospitals. Denied cases are by definition not inpatient cases and thus not eligible for the CPC. The submission of these inaccurate monthly revenue and volume reports to the HSCRC has resulted in the generation of excessive charging capacity.

Staff also believes that the policy rationale for excluding these cases from a hospital's CPC is equally clear. Hospitals with cases that have been denied based on medical necessity determinations should not have the ability to recoup these lost amounts by charging higher rates to all payers.

5 – Hospitals are Subject to Fines Associated with Inaccurate Reporting of the Cases to the HSCRC.

The inaccurate submission of monthly revenue and volume reports to the HSCRC has likely been occurring for a number of years. The collection of denied case data for FY 2009 (see table 5 below) indicates that most, if not all hospitals have been inaccurately reporting denied cases as inpatient cases eligible for the CPC. The HSCRC has statutory authority to impose fines on hospitals for delinquent and inaccurate reporting. The staff believes that hospitals that have submitted these inaccurate reports could be subject to fines of $250 per day from the time these reports were due to the HSCRC. Staff has evidence of inaccurate reporting for FY 2009 as noted. Reports pertaining to years prior to FY 2009 may also be subject to HSCRC fining authority.

6 - Current and Growing Budget Deficits at both the State and Federal Levels are Placing the System under Increased Pressure to Deliver Improvements in Efficiency and Reductions in Waste.

As noted, the current policy focus both nationally and at the state level on expanding access to care has necessitated a renewed emphasis on finding ways to make health care less costly and more affordable to the paying public. The experience of states like Massachusetts and Maryland make the link between cost and access painfully obvious. Additionally, growing and serious budgetary shortfalls at both levels are exacerbating this focus on reducing health care costs. Both factors will inevitably require large-scale reductions in provider payments in the future. These reductions can be structured in the form of arbitrary cuts (such as Medicaid day limits of the past, or the proposed Medicare payment cuts in the future) or by changing payment incentives designed to change provider behavior and mandate higher levels of efficiency and effectiveness. Policy-makers realize that it is far preferable to promote efforts to remove waste and inefficiency in the system. The proposed changes to HSCRC payment methods associated with one-day LOS cases and denied cases are in the category of changing incentives to promote efficiency. Failure to adopt these changes will necessarily mean the system will be vulnerable to the arbitrary cuts in the future.

7 - One-day LOS cases and Cases Admitted Inappropriately will be a Focus for the RAC Audit Review by The Centers for Medicare and Medicaid Services.

Given the data presented above and based on discussions with CMS and RAC personnel, it is clear that Maryland hospitals are vulnerable to large numbers of additional denials associated with one-day stays (going back three years) from RAC audit activities. These activities are likely to become increasingly aggressive as the federal government looks for more ways to lower health care costs and generate savings to help offset the projected insolvency of the Medicare Trust Fund in 2017. The RAC audit activities thus are expected to continue in future year however, and hospitals will be forced to respond to RAC denial recommendations and potential payment reductions. These determinations will likely spawn considerable expenditure of effort to appeal RAC payment cuts resulting in a further unnecessary expenditure of resource. Staff believes a better way to reduce unnecessary admissions of one-day stays moving forward would be through a change in overall hospital financial incentives through the rate setting mechanisms of the HSCRC.

Staff Proposals

Given these circumstances, staff is recommending two changes to its Charge per Case methodology in order to both remove revenues gained through inclusion of denied cases under the CPC, and a mechanism to reduce the incentive to unnecessarily admit one-day stay cases. Additionally, staff is recommending that the HSCRC discuss the benefits of a more systematic approach to reducing one-day stays in Maryland (through broad incentive based changes to the rate setting system) with the Center for Medicare and Medicaid Services (CMS) as a potential alternative to intensive RAC review of these practices and case by case denial by Medicare.

The goal of this recommendation is not to eliminate all one-day LOS cases. Rather, the goal is to both simultaneously remove some proportion of the rate capacity generated from admitting cases that should rightfully be treated on an observation (outpatient) basis, and, at the same time, still allow considerable leeway for appropriate medical decision-making (note – even with the application of the proposed rate incentives, a majority of the rate capacity generated by hospitals will remain in their inpatient DRG weights). Certainly, for a proportion of these short-stay cases, the decision whether or not to admit is anything but clear. However, for a larger proportion of these cases, hospitals nationally appear to be in a position to treat these cases quite effectively on an outpatient basis. Maryland hospitals should be incentivized to do so as well – resulting in improved hospital efficiency and better outcomes.

Proposed Method to Reduce Current Excessive Incentives to Admit One-Day LOS Cases

As noted, staff believes there is a need to put in place a structure that will incentivize hospitals to shift a portion of inpatient one-day LOS cases to the more appropriate outpatient setting and remove some of the excess rate capacity in the system that is driving the less efficient behavior by hospitals. The proposed approach focuses on only a portion of the existing rate capacity that hospitals currently earn for one-day LOS cases.

This methodology will quantify the charge capacity generated at each hospital for one day stay cases that exceed a reasonable standard. FY09 data will be used to set the expected rate of one-day LOS cases by APR/SOI (severity of illness) and performance will be measured in FY2010. The following describes the steps to calculate the better practice standards, 'excess' one-day stay cases, and the rate capacity associated with the excess cases:

Step 1 - Method to develop 'best practice' 1-day LOS standard for each APR/SOI:
For each APR/SOI, calculate the percent of 1-day stay cases by hospital. Develop a 'better practice' standard rate of 1-day LOS cases for each APR/SOI by only using hospitals in the bottom 50th percentile for the 1-day LOS rate. Using this better practice standard, rather than the statewide percent, is more commensurate with the better practice already in play nationally for one-day LOS cases.

Step 2 – Calculation of excess 1-day LOS cases:
Multiply the better practice standard, as developed in Step 1, by the total cases in the corresponding APR/SOI at each hospital to determine the 'expected' number of 1-day LOS stay cases for each APR/SOI. For each hospital, subtract the expected number of 1-day LOS cases from the actual to determine the number of excess 1-day LOS cases in each APR/SOI.

Step 3 – Calculation of rate capacity associated with excess 1-day LOS cases:
For each hospital, calculate the approved revenue associated with the excess 1-day LOS cases in each APR/SOI as follows: multiply the excess number of cases by the hospital's CPC at a CMI of 1.0 (CPC/base CMI) and by the case weight of the APR/SOI.

Rate capacity is defined as the difference between the approved revenue for a case minus the total charge for the case. The rate capacity for the excess 1-day LOS cases in each APR/SOI is, therefore, the approved revenue, as calculated above, minus the average charge for all 1 day LOS cases in the corresponding APR/SOI multiplied by number of excess cases. The following is an example calculation of the rate capacity associated with excess 1-day LOS cases in an APR/SOI at Hospital A:

a	b	c	d	e	f	g	h	i	j	k	l	m
				*c*d*		*f-e*			*g*h*i*		*g*k*	*j-l*
APR	SOI	% of 1-Day LOS Cases Standard	Hospital Total Cases in APR/SOI	Hospital Expected 1-Day LOS Cases in APR/SOI	Hospital Actual 1-Day LOS Cases in APR/SOI	Hospital Excess 1-Day LOS Cases in APR/SOI	Hospital CMI @ 1.00	APR/SOI Weight	Approved Rev for Excess Cases	Avg. Charge for all 1-Day LOS Cases in APR/SOI at Hospital	Total Charges for Excess Cases	Rate Capacity Assoicated with Excess 1-Day LOS Cases
47	2	30%	100	30	45	15	$8,800	0.6000	$79,200	$4,000	$60,000	$19,200

Total rate capacity associated with excess one-day LOS cases at each hospital is the sum of the rate capacity calculated for each APR/SOI. This total amount will be applied as a penalty on CPC compliance for FY2010. Inpatient revenue will be reduced as hospitals react to the threat of impending RAC audits and the proposed incentive (penalty) changes to the CPC. The purpose of this proposed methodology is to reduce existing rate capacity that has been built into DRG weights of all cases. If hospitals are able to shift a portion of these cases to outpatient observation in FY2010, the penalties will be lower. That, combined with the ability to charge these cases as observation in the outpatient setting, will reduce the potential negative financial impact to hospitals.

Excess Rate Capacity by Hospital and Calculation of Incentive (Penalty)

Table 6 shows excess rate capacity being generated by hospitals on one-day LOS cases from FY 2009 and the proposed incentive (penalty) to be applied to hospitals that have one-day stays in excess of the "Better Practice" standard calculated by each APR/SOI cell. Better practice standard was calculated as the average of the best 50th percentile of Maryland hospital performance on one-day stays within each APR/SOI cell. This better practice performance standard equates to roughly an overall one-day LOS proportion of 15.5% of cases (a standard that approximates the performance of hospitals nationally for 2010 and future years). **Table 6** also shows how the proposed rate incentives would be applied to hospitals if they do not shift cases that can appropriately be treated on an observation basis to that outpatient setting per the methodology described in the previous section. The annualized penalty being proposed would be $149,834,823 across all hospitals. This table only reflects a half year impact. This amount is further reduced by the amounts that hospitals are anticipated to remit directly to the Department of Health related to the budgetary action by the State Board of Public Works (July, August and November approved action) and the approved Medicaid expenditure reductions approved in the Supplemental budget #2 from the 2009 General Assembly (a total of $27.8 million reduction in penalty amounts).

Table 6

Rate Capacity Associated with One-Day Stay Cases and "Excess" One-Day Stay Cases

A	B	C	D	E	F	G	H
Hospital Name	Cases after Exclusions (1)	Associated Charges	1-day Stay Cases after Exclusions (1)	1-day Stay Charges	% of Cases 1-day Stays	"Excess" (2) Rate Capacity	Proposed Penalty (3)
Upper Chesapeake Medical Center	13,483	$114,666,090	4,614	$21,813,976	34.22%	$6,461,285	$1,318,214
Franklin Square Hospital Center	23,324	$239,797,092	7,619	$36,654,460	32.67%	$18,603,465	$4,319,969
Union Memorial Hospital	19,805	$292,972,181	6,192	$54,326,430	31.26%	$13,657,699	$3,501,109
St. Mary's Hospital	8,147	$57,512,970	2,486	$7,940,438	30.51%	$4,300,029	$323,712
Calvert Memorial Hospital	6,818	$53,252,523	2,050	$7,957,439	30.07%	$3,259,781	$412,748
St. Joseph Medical Center	20,490	$258,381,532	5,894	$42,580,025	28.77%	$13,331,598	$2,065,392
Carroll Hospital Center	13,925	$126,382,478	3,975	$16,310,472	28.55%	$7,080,799	$1,457,196
Mercy Medical Center	14,105	$157,442,049	3,925	$23,071,655	27.83%	$7,951,297	$1,828,121
Harford Memorial Hospital	7,149	$55,295,540	1,964	$8,047,644	27.47%	$3,627,363	$588,638
Garrett County Memorial Hospital	2,024	$15,634,024	545	$1,722,808	26.93%	$887,707	$136,810
University of Maryland Hospital	22,595	$502,210,531	5,974	$44,751,540	26.44%	$25,489,935	$4,979,718
Anne Arundel Medical Center	17,430	$193,167,438	4,569	$26,074,212	26.21%	$8,223,626	$1,569,509
Johns Hopkins Hospital	37,192	$781,949,531	9,598	$79,495,102	25.81%	$37,510,236	$10,338,853
Washington Adventist Hospital	14,347	$170,965,405	3697	$25,187,497	25.77%	$10,123,272	$1,452,696
Suburban Hospital	13,927	$153,941,122	3,581	$22,070,415	25.71%	$5,989,388	$841,332
Union of Cecil	6,923	$56,977,659	1,769	$5,787,676	25.55%	$2,797,079	$348,633
St. Agnes Hospital	17,749	$206,853,302	4,473	$24,618,173	25.20%	$12,134,042	$1,801,477
Civista Medical Center	6,281	$53,774,905	1,518	$4,855,260	24.17%	$3,080,488	$40,947
Doctors Community Hospital	11,021	$101,082,929	2,634	$8,465,200	23.90%	$5,316,786	$470,539
Prince Georges Hospital Center	10,626	$139,257,948	2,504	$12,679,120	23.56%	$6,051,216	$440,517
GBMC	15,775	$175,543,572	3,698	$21,263,267	23.44%	$6,693,694	$476,156
Harbor Hospital Center	10,847	$120,550,554	2,516	$12,821,586	23.20%	$4,808,756	($98,650)
Southern Maryland Hospital Center	13,699	$123,224,213	3,024	$11,531,914	22.07%	$5,233,116	$38,416
Sinai Hospital	20,805	$324,595,720	4,589	$33,054,058	22.06%	$10,408,016	$1,728,081
Shady Grove Adventist Hospital	15,672	$151,712,445	3,457	$14,923,217	22.06%	$5,842,330	$145,206
Baltimore Washington Medical Ctr.	17,868	$180,916,210	3,923	$17,880,762	21.96%	$10,036,294	$1,602,439
Braddock-Sacred Heart Hospital	8,962	$81,600,758	1,946	$10,581,964	21.71%	$2,968,721	($246,796)
McCready Memorial Hospital	564	$5,404,412	122	$508,364	21.63%	$207,768	($1,235)
Holy Cross Hospital	16,385	$184,160,086	3,542	$14,481,409	21.62%	$7,511,535	$322,524
Good Samaritan Hospital	16,305	$192,733,071	3,480	$16,755,457	21.34%	$7,080,979	$1,093,470
Chester River Hospital Center	2,947	$26,003,173	613	$2,025,889	20.80%	$1,423,680	($102,976)
Fort Washington Medical Center	2,681	$21,827,221	536	$1,924,578	19.99%	$775,191	($86,439)
Howard County General Hospital	10,257	$102,512,570	2,047	$9,446,172	19.96%	$3,939,944	$502,857
Atlantic General Hospital	3,380	$34,346,646	668	$2,582,846	19.76%	$1,248,424	$106,881
Memorial Hospital at Easton	8,171	$79,673,722	1,583	$7,077,266	19.37%	$3,732,101	$624,745
Johns Hopkins Oncology	4,726	$148,652,552	908	$8,142,357	19.21%	$4,003,371	$1,331,007
Northwest Hospital Center	11,852	$120,332,081	2,274	$8,623,118	19.19%	$4,225,547	$45,067
Johns Hopkins Bayview Medical Ctr.	17,323	$231,055,179	3,311	$18,188,759	19.11%	$8,021,893	$445,120
Memorial of Cumberland	5,972	$57,710,826	1,118	$3,933,582	18.72%	$2,383,459	($228,543)
Peninsula Regional Medical Center	17,911	$229,547,974	3,313	$22,761,687	18.50%	$6,013,372	($123,729)
Washington County Hospital	13,115	$132,428,967	2,378	$9,059,382	18.13%	$4,788,123	$355,401
Montgomery General Hospital	8,534	$81,908,827	1,460	$5,910,888	17.11%	$2,703,416	$129,835
Maryland General Hospital	9,472	$117,341,166	1,569	$7,712,551	16.56%	$3,479,370	$801,085
Dorchester General Hospital	3,377	$27,179,818	557	$1,630,897	16.49%	$1,406,428	$109,889
Laurel Regional Hospital	5,229	$47,776,749	857	$3,719,457	16.39%	$1,765,296	($134,761)
Frederick Memorial Hospital	13,765	$132,005,271	2,142	$7,741,996	15.56%	$4,827,404	$3,769
Sinai Hospital Oncology	1,458	$26,158,292	192	$956,590	13.17%	$822,107	$333,269
Bon Secours Hospital	6,359	$70,204,150	728	$3,703,312	11.45%	$1,000,201	($278,018)
Univ MD Oncology	1,261	$37,422,208	84	$431,861	6.66%	$343,542	($11,098)
James Lawrence Kernan Hospital	2,578	$45,144,917	114	$744,588	4.42%	$334,549	($85,753)
Totals	574,611	$7,041,190,599	136,330	$754,529,316		$313,905,718	$47,033,351 (3)

(1) Exclusions: transfers, deaths, left against medical advice, and OB and newborn DRGs

(2) "Excess" rate capacity is the extra rate capacity (over and above actual charges for one-day cases, generated by admitting one-day LOS cases assuming that hospitals do not respond to the incentive and they do not shift observation eligible patients to the outpatient setting. This penalty is shown also assumes a prospective implementation (effective January 1, 2010) over the next 6 months (one half a rate year) and adjusts for amounts that hospitals are anticipated to pay to the Department of Health in response to State action to generage required budgetary savings ($27.3 mill.)

Table 7 provides an overall summary of total cases, one-day stay cases and associated charges and rate capacity by category. The table shows Maryland's proportion of one-day LOS cases is approximately 23.7% in 2009 vs. estimated national proportion of one-day stays of 16.6% (2006 data). Maryland is approximately 7.2% higher than hospitals nationally. This very large difference is not explained by differences in the mix of (rural/ urban) in Maryland vs. the U.S.

The table also shows that while each one-day stay generates approximately $5,156 dollars in charges on average, hospitals receive rate capacity of $7,736 on average (for an excess rate capacity of $2,581 per case for every one-day stay case they admit).

Table 7

Simulation of Overall Revenue and Case Mix Impacts
if Hospitals Shift Observation-Eligible Cases to Outpatient Settings

Overall Cases & Overall One-day Stays (FY 2009)

	A	B	C	D	E	F
	Cases	Charges	CPC	Total Rate Capacity	Rate Capacity Per Case	Excess Rate Capacity per Case Col. E - C
All Inpatient Cases	761,610	$8,547,321,110	$11,223			
All One-day Stays	164,212	$846,677,844	$5,156	$1,270,461,592	$7,736.72	$2,581
Proportion 1-day Stays	21.56%					
Cases After Exclusions						
All Inpatient Cases	574,611	$7,041,190,599	$12,254			
All One-day Stays	136,330	$754,529,316	$5,535	$1,068,435,034	$7,837	$2,303
Proportion 1-day stays	**23.73%**					
US Proportion 1-day stays (in 2006)	**16.58%**					
Excess 1-day stay % in MD	7.15%					

Table 8 (below) is a summary of the impact to revenues and case mix under three "what-if" scenarios: 1) no shifting of cases to outpatient observation (which triggers the full penalty for hospitals with excess numbers of one-day LOS cases); 2) results assuming a 16% shift of one-day stay cases; and 3) results assuming a 28% shift of one-day stay cases.

Table 8

Simulations of Overall Revenue Results assuming two scenarios:

Scenario 1) 16% of 1-day cases (or 3% of total cases) shift to Outpatient Observation Status
Scenario 2) 28% of 1-day cases (or 6.6% of total cases) shift to Outpatient Observation Status

	A	B	C	D	E	F	G
	Shifted Cases	Original Total Inpatient Charges	Reduction to Inpatient Revenue Due to Shift	New Total Inpatient Charges After Shift	Original Average CMI	New Average CMI	CMI Change
Scenario 1) 16% shift to Outpatient							
Shifted Cases	21,813	$8,547,321,110	$168,760,984	$8,378,560,126	1.03338	1.04284	0.92%
Rate capacity per case	$7,737						
Scenario 2) 28% shift to Outpatient							
Shifted Cases	38,172	$8,547,321,110	$295,331,722	$8,251,989,388	1.03338	1.05032	1.64%
Rate capacity per case	$7,737						

Summary of Overall Revenue Changes by Scenario (Annualized Basis)

	No Change in 1-day LOS cases	16% Shift in 1-day LOS cases	28% Shift in 1-day LOS cases
Inpatient Revenue Reduction	0	$168,760,984	$295,331,722
Application of Incentive (Penalty) (1)	$121,950,762	$68,447,033	$31,857,688
Additional Outpatient Revenue (New OBS cases) (2)	0	$112,467,931	$196,815,011
Overall Revenue Change	$121,950,762	$124,740,086	$130,374,399

Note: (1) Incentive (penalty) amount is reduced by $27.8 million associated with hospital share of FY 2010 budget cuts
(2) Outpatient charges per case are assumed to be roughly equaly to the inpatient charges per case for these 1-day LOS cases

The summary box at the bottom of **Table 8** shows the imposition of the full penalty under an assumption of no shifting; a $168.8 million inpatient revenue reduction in and $68.5 million penalty under the 16% shift scenario – offset by new outpatient charges of $112.5 million; and $295.3 million in inpatient revenue reductions and $31.9 million in penalties – offset by $130.4 million in additional outpatient charges under the 28% shift scenario.

Again, the purpose of the penalty is to simultaneously provide sufficient and systematic incentives to change hospital behavior (induce them to establish observation units and utilize them) and also to reduce some of the existing excessive rate capacity generated historically by the practice admitting virtually all observation-eligible cases.

Hospital Charging Capability for Observation Cases

During staff's discussions with hospital representatives regarding one-day LOS cases, questions have been raised about the most appropriate method for charging for outpatient observation cases. In particular, some representatives have voiced a concern that hospitals do not have an adequate means of charging for resources expended during the observation process.

Staff believes that hospitals have the ability to charge for observation patients now. In the past staff proposed modifications to the charging structure for OBS patients. Staff believed these modifications represented improvements to the charging structure for these cases, but in the the industry rejected the proposed changes. In the most recent meeting on the one-day LOS issue, the industry indicated it was now receptive to such changes.

Staff, however, does not believe the initiative to incentivize hospitals to shift observation-eligible cases to the outpatient setting should be put on hold pending these modifications. For the reasons articulated, it is important to move deliberately to reduce excess revenues and improve hospital efficiency. Any necessary structural changes to rates can be developed along with the implementation of the staff proposed rate changes.

The description of Observation services and instructions on how to charge for OBS are included in Emergency Services – Standard Unit of Measure References – Appendix D and summarized below in **Figure 2**. Staff believes that these procedures provide hospitals with sufficient charging abilities for OBS cases. If however, individual facilities have remaining questions or concerns, the staff will work with these hospitals to help clarify current instructions or make any necessary modifications.

Figure 2

Instructions from HSCRC Accounting and Reporting Manual regarding OBS Services

The primary purpose of OBS is to determine whether the patient is to be admitted as an inpatient or not.

This service must be ordered and documented in writing by a medical staff practitioner.

OBS includes the use of a hospital bed and periodic monitoring by nursing or other staff, which are deemed reasonable and necessary to evaluate the patient's condition and determine the need to admit or not.

The service includes does not have to be provided within the ER. Can be provided anywhere in hospital.

An OBS patient may have an ER charge or not depending upon whether they are a direct admit to OBS directly from home or a physician's office (with the order given by the patient's physician) or come through the ER.

For each hour of OBS clock time the hospital can charge 1.5 ER RVUs. (This level of charging was assigned so that 24 hours of OBS (36 RVUs) approximated a one day inpatient room & board charge.) If hospitals can provide evidence that the current charge structure is inadequate to cover the cost of OBS services, adjustments can be made.

Impact on Case mix

The implementation of the proposed policy will also have other impacts on both overall case mix growth (the removal of less severe cases from inpatient revenue will mean some increase in hospitals' measured case mix during the course of FY 2010 and in future years). Staff has yet to precisely forecast the case mix impact although it believes it can develop a reasonable way of accounting for case mix change attributable to the shifting of observation-eligible one-day LOS cases. It is staff's intent to recognize case mix increases attributable to the shift in observation-eligible (stemming from the implementation of this recommendation) cases to outpatient settings in the allowed case mix adjustment for individual hospitals. The projected case mix impact of a 16% and 28% shift in observation-eligible cases is shown in **Table 8.** These shifts would increase inpatient case mix (which staff would recommends would not be subject to the FY 2010 case mix governor of 0.5%) by 0.92% and 1.64% respectively.

Impact on Medicare Waiver

One impact of Maryland's high proportion of one-day length of stay cases has certainly been to raise the overall cost of health care to the public beyond what is both demonstrably achievable (given other states' performance) and ideally most efficient for the Maryland hospital system. While having one of the highest proportions of one-day LOS cases has negatively contributed to overall health care costs in the State, it also has the effect of artificially deflating Maryland hospitals' average cost per case or average payment per case. The State has more cases - resulting in higher than appropriate overall expenditures, but lower average costs per case or payments per case. This means that the State's performance on the both its NPR per case comparison and its Medicare waiver test (which based on a comparison of per case payments – Maryland vs. the US) have been more favorable due to Maryland's higher proportion of short stay cases and thus lower overall payment per case. While this circumstance makes Maryland appear more favorable relative to the nation – it masks the fact that higher proportions of patient treated on a very costly inpatient basis actually means overall hospital payments in the State are more than they should be and Maryland hospitals are less efficient than their counterparts in the U.S. on this dimension. Any policy change that cause hospitals to shift one-day LOS cases out of the inpatient setting, will increase case mix and average payments per case in Maryland thus contributing to an erosion in our waiver test.

While this is largely not the case under the proposed handling of denied cases (per this recommendation – because under this proposed methodology change the full DRG weight will be removed), the State can expect to see some erosion on its Medicare waiver performance if staff's additional proposed incentive system results in a shift of one-day cases to outpatient care. It is difficult to forecast the impact both the treatment of RAC audit challenges and/or the imposition of a targeted incentive structure will have on shifting proportions of one-day cases to outpatient observation, however, the Commission should anticipate some magnitude of shift and an associated deterioration on our Medicare waiver test.

Table 9 provides a preliminary projection of a worst case impact on our waiver test after full implementation (two – three years) of the proposed policy changes.[5]

[5] Note - two possible mitigating factors will be the simultaneous permanent removal of inpatient revenue in Maryland (both as a result of hospitals shifting inpatient cases to the outpatient setting and the imposition of the proposed rate incentives

Table 9

Worst Case Impact on Medicare Waiver

Waiver Base Year pmts (base 1981)	Maryland Medicare Pmt per case $2,972	Cumulative Growth since 1981	US Medicare Pmt per case (2) $2,293	Cumulative Growth since 1981	Relative Cushion	Waiver Test Estimate with Techinical Correction (3)(4) (5)
MD Q2 Waiver Result (1)	$11,688	293.27%	$9,610	319.10%	6.57%	
1.0% reduction	$11,755	295.51%	$9,610	319.10%	5.97%	7.49%
2.0% reduction	$11,822	297.79%	$9,610	319.10%	5.36%	6.88%
3.0% reduction	$11,892	300.13%	$9,610	319.10%	4.74%	6.26%
4.0% reduction	$11,962	302.51%	$9,610	319.10%	4.12%	5.64%

Note:
(1) Assumes 14.7% of Medicare cases are 1 day LOS (per case mix data)
(2) Not estimated - but would be reasonable to assume that given RAC impacts nationally US 1 day cases will also diminish - this will have the effect of improving our waiver test (albeit not at the same rate our test erodes given Maryland's likely reduction in 1 day LOS Mcare cases)
(3) Staff is simultaneously are working to ensure CMS actuary makes agree-upon technical adjustment to waiver test
(4) Staff believes other technical (positive) adjustments to the Maryland performance on the waiver test are warranted
(5) Staff notes also that reductions in Chronic hospital Medicare cases in Maryland also will have a significant positive impact on the waiver test

Proposed Method to Adjust CPC for Denied Cases

As noted, under the HSCRC's CPC rate methodology, denied cases have been reported to the Commission in the HSCRC's monthly revenue and volume reports and case mix data tape. The inappropriate inclusion of these denied inpatient cases allows hospitals to generate "rate capacity" associated with their full DRG case weight (even though original payment for the case was denied based on medical review criteria). Hospitals are thus allowed to raise their rates to all payers to generate revenues for these denied cases. Staff does not believe this is an appropriate result.

Staff believes that medical necessity decisions should be upheld (particularly since hospitals have access to an elaborate appeals and grievance process through the Maryland Insurance Administration). The public should not be forced to pay for these cases if they have legitimately been determined to be unnecessary.

Accordingly, staff has instituted a reporting (and auditing) system to collect data, on the number of denied cases experienced by hospitals (after any appeals process has been exhausted). These cases will be removed from the hospitals' Charge per Case compliance data and the full DRG-weights associated with each case should be removed from each hospital's approved CPC and approved overall inpatient revenue. Table 5 (shown above) indicates Maryland hospitals reported denied case data for a period of 9 months during FY 2009. Based on these data (and extrapolating from this 9 month case total to a full 12 months), it appears that Maryland hospitals have approximate 4,000-5000 denied cases annually.

(penalties). Also, hospitals nationally are expected also to decrease their proportions of one-day LOS cases in response to RAC audits nationally. This action will have the effect of increasing national Medicare payments per case for the cases that remain treated on an inpatient basis (thus offsetting some of the increased Maryland Medicare payments per case associated with the same phenomenon here).

Given that a majority of these cases are likely either zero or one-day LOS cases, and the average DRG weight (full "charge capacity") associated with one-day LOS cases is approximately $7,500 per case, it anticipated that the removel of full DRG weights associated with denied cases will reduce hospital approved revenues by some $30-37 million annually. Hospitals of course can make up for some of this lost revenue in future years by treating some or most of these cases on an outpatient observation basis where the average charge could be as much as $5,000 per case. **Table 5** shows the 9 month data for FY 2009 submitted to the HSCRC.

Similar reporting will be accomplished on a quarterly basis in FY 2010. If approved by the Commission, this policy will result in the removal of all FY 2010 denied cases from the CPC and approved hospital revenue on a permanent basis. The intent of this policy is to treat the denied case as if it never occurred in the first place.

Summary

As articulated, staff believes the Commission should move to change the incentives in the rate setting system to help improve hospital efficiency related to the two issues – treatment of observation-eligible one-day LOS cases, and denied cases inaccurately reported to the Commission for inclusion in the HSCRC CPC methodology.

The current financial incentives in the system are excessive. This results in additional and unnecessary costs to the paying public and dilutes the incentive of hospitals to improve efficiency.

In an era of expanding access to care, lowering cost and expanding the affordability of care, along with the increasing demand from public payers to improve efficiency and reduce waste to address budgetary shortfalls, the status quo system of excessive hospital payments should not be preserved.

Recommendations:

Based on the above analysis, and given the current and urgent need to reduce waste and inefficiency in the health care system overall, staff is making the following recommendations:

1. For rate year FY 2010 all denied cases and associated DRG-weights should be accounted for and removed from the calculation of each hospital's approved Charge per Case and Approved Revenue. Hospital approved CPC and approved revenue should be reduced on a permanent basis by each hospital's quarterly report of denied cases and the associated DRG weights of these cases. Staff will link the reported denied cases to the case mix data (to determine the associated DRG weight of each case) and remove the case and revenue from each hospital's financial data (used for calculation of CPC compliance);

2. The HSCRC should assess fines for rate year FY 2009 on hospitals who inaccurately reported inpatient admission cases (that were subsequently denied on the basis of a medical necessity review) to the HSCRC for the purposes of calculating that hospital's CPC constraint and are the

basis for that hospital's approved inpatient revenue. The staff would further recommend suspension of these fines pending accurate reporting of these data to the Commission for a period of 24 months from July 1, 2009. Failure to adhere to approved Commission action regarding denied cases (per this recommendation) or future inaccurate reporting, of denied cases (per the newly instituted denied case report or the HSCRC monthly revenue and volume reports) would trigger imposition of the calculated fine.

3. For the half of the rate year FY 2010 (effective January 1, 2010) a system of rate incentives (penalties) should be applied to hospitals whose overall rate of one-day LOS cases is in excess of an expected standard. This calculation will be based on comparing each hospital's performance of actual number of one-day LOS cases to an expected or "better-practice" standard on a DRG-SOI cell basis. The expected or "better practice" standard level will be determined based on the performance of the bottom two quartiles of Maryland hospitals. This rate incentive (penalty) will be applied to each hospitals approved Charge per Case for compliance purposes during the rate year FY 2010 as described in the body of this recommendation. Additionally, staff would recommends that the amount of the penalty applied to each hospital be offset by amounts hospital-specific amounts remitted by hospitals to the Department of Health related to the 2010 Board of Public Works budget cuts and the 2009 Budget Bill (supplement # 2) payment cuts as approved by the Commission at its December 9, 2009 public meeting.

4. Any case mix change associated with the shift of one-day stay eligible cases from inpatient to outpatient observation should be recognized by the HSCRC and not be subject to the case mix governor of 0.5% (approved by the Commission in May of 2009 for the FY 2010 rate year).

5. Staff would seek to negotiate with the Centers for Medicare and Medicaid Services to obtain a waiver from RAC audit activities targeted at denying payment for "excessive" one-day LOS cases in lieu of the application and continuation of this broad-based and more systematic incentive based approach to reduce excess one-day LOS cases in the system.

Appendix I

MHA Presentation from 11/30/09 – Outlining the Industry Position on the Staff's One-day Length of Stay and Denied Case Recommendations

Maryland Hospital Association

HSCRC Proposal:

"One Day Stay" and Related Issues

November 30, 2009

Discussion Topics

- Overview
- Background
- Proposed System Conversion:
  - Inpatient CPC, Case Weights, CMI and CMI Governor
  - Case Mix Governor
  - Outpatient Charge Structure
  - Inpatient Denials
  - Effective Date and "Look back"
- Summary
- Appendix

Overview

- "One Day Stay" (ODS) cases have always been a part of the HSCRC's Rate Setting system. In Maryland, ODS cases as a percentage of total cases has remained constant over a long period of time.
- Revenues should reflect the cost of care in the most appropriate setting. The decision to admit or observe a patient is a complex medical decision. The health services literature suggests that not all ODS cases are appropriately treated in an outpatient setting
- Service changes are perceived to be ***cost*** neutral. Associated revenue changes should correlate to cost and also be neutral.
- In FY2009, cases with a LOS greater than 1 reduced rate capacity by $392m, as compared to $385m of rate capacity generated by ODS cases. The ODS issue focuses on the structure of payments, not the level of payments.
- HSCRC proposed financial penalties do not address the fundamental cost allocations and revenue realignments required to expand the use observation services.

Overview

- The HSCRC's rate setting system should align payments appropriately, by:
  - Reducing inpatient payments for ODS cases and adjusting inpatient payments for other cases
  - Modifying outpatient charge structures to align charges with resource use and underlying costs
  - Eliminating the effect of the CMI Governor for appropriate and necessary movement of ODS cases to observation
- These changes address the system as a whole, adjusting and realigning revenues based on underlying costs in an effective manner.
- Similar to past "rate conversions," a comprehensive system conversion should occur to realign revenues and costs in a revenue neutral manner.

Background

- The HSCRC's Charge per Case system, by definition, is a system of averages.
- Cases of all lengths of stay are grouped into an APRDRG/SOI, based on the same diagnoses and procedure codes.
  - In each cell, cases with shorter lengths of stay have lower charges than cases with longer lengths of stay. When blended together, they create the average charge for that APRDRG/SOI cell.
- The "Case Weight" is determined by dividing the average APRDRG/SOI for each cell by the overall statewide average for all cells.
- All cells have "winners" and "losers," based on actual charges.

Background

- Shifting ODS cases to outpatient will result in two separate and distinct financial impacts:
  - Significant loss of revenue
    - A hospital's revenue base will be reduced, by reducing payment levels from the average inpatient payment to the actual outpatient payment.
    - Since payments are developed on average, this is caused by eliminating cases below the average (LOS = 0 or 1) without simultaneously increasing payments above the average (LOS > 1).
  - Substantial CMI Governor impact
    - The ODS CMI average of 0.82 (1) is lower than the state average 1.00.
    - Shifting ODS cases to outpatient will increase overall CMI, subject to the CMI governor.
    - Shifting ODS cases to outpatient reflect "real" changes in remaining inpatient resource use and should not be subject to the governor.
- Appendix A quantifies the impact of shifting 25% of all ODS cases to outpatient, assuming average "actual" and "approved" CPC, and CMI.

Note (1): Estimated using FY2009 Level 1 data. Case weights computed by dividing average charge per APRDRG by overall average charge. Estimated weights applied to ODS cases to compute ODS CMI.

Proposal: Inpatient Charge per Case, Case Weights, CMI and CMI Governor

- Adjust the CPC system to realign payment incentives, using one of two options:
  - Exclude ODS Cases in some manner from Charge per Case. This may be all ODS cases, select APRDRGs, or select APRDRG/SOI cells; or
  - Adjust the average case weights to reduce payment for ODS cases and increase payment for other cases.
- Key consideration: In conjunction with CPC/CMI changes, outpatient payments should reflect the true costs of services to equal ODS "Actual" inpatient charges. (Subsequently discussed)
  - Appropriately aligns payment levels: Inpatient ODS, Inpatient non-ODS, and, Outpatient Observation.
  - Either option must be done in conjunction with rebasing the outpatient charge structure to align all revenues (inpatient and outpatient) based on underlying costs.

Proposal:
Option 1 – Exclude ODS Cases

- Move "actual" charges for ODS cases from included (Level 1), to excluded (Level 3), similar to existing low charge exclusions
- Case Weight / CMI Options:
  - Rebase Case Weights CMI.
  - Recalculate CMI base without rebasing.
- By definition, excluding ODS cases from the CPC/CMI measurement will eliminate the impact of the CMI Governor.
  - ODS cases will not affect CMI change if they are excluded from both the base and the current period.
  - Provides a systematic approach to addressing ODS impacts on future CMI governors.
  - As noted by Staff in prior years, "real" CMI changes that should be handled outside of the CMI governor are difficult to isolate.
- Appendix B reflects the mechanics of Option 1.

Proposal:
Option 2 – Adjust Average Case Weights

- Adjusting the average case weights to reduce payments for ODS cases and increase payments for other inpatient cases.
- In this option, case weights would be adjusted in each APRDRG/SOI cell between ODS cases and non-ODS cases.
- Option 2 does not eliminate the effect of the CMI governor.
  - ◇ A concurrent adjustment to the CMI governor must be computed and applied to each hospital's CMI change as a result of shifting cases to observation.
  - ◇ The number of observation cases could be determined in the base period, with an adjustment for any volume change in the current period.
- Appendix C reflects the mechanics of Option 2.

Proposal: Outpatient Charge Structure

- An integral part of the proposed system conversion requires changes to the HSCRC's outpatient charge structure.
- There are two key components required:
  - Creating a separate and distinct rate for Observation Services (Medical observation)
  - Creating a tiered rate structure for Same Day Surgery (SDS) services (Surgical recovery)
- As stated previously, the revenue in each rate center should be developed via a "rate conversion," based on the underlying costs.
  - In the current model, observation costs and statistics are, or should be, captured in the EMG rate center.

Proposal: Medical Observation

- The HSCRC system allows every hospital to charge for observation services via its EMG rate.
  - 1.5 RVU for every hour of observation
- Prospectively, a separate rate center for medical observation is more practical to capture costs and charges, and, to separate medical observation services from routine Emergency services. Outpatient observation charges will be appropriately reflected, based on underlying costs.
- Observation service delivery varies across the state, from distinct observation units to available "inpatient" beds.
- To establish this new center, a rate conversion should capture costs and charges from EMG, plus nursing and other costs from the routine centers (if used to provide observation services). These costs should include the expected costs for new or expanded observation services.
  - A revenue neutral rate adjustment, or realignment, should be performed to establish the new rate center.
  - EMG (and likely routine) charges will be reduced as hospitals allocate observation costs appropriately.
- The rate center should be charged "per hour of care" (or per RVU, with 1 RVU = 1 hour of care)
- This full cost realignment will offset part of the negative Waiver impact, as costs and revenues are realigned to from inpatient to outpatient.

Proposal: Surgical Recovery

- Similar to Medical Observation, the existing Same Day Surgery (SDS) center must be "converted" to reflect the costs of extended recovery.
- First, a tiered structure should align payment with resource use.
  - ◇ An hourly, or at least, multi-tiered per visit charge structure should be considered.
- Second, the costs for extended recovery should be captured and reclassified from other areas (routine centers, etc.), including expected costs for new or expanded outpatient surgical cases.
- In conjunction with creating a distinct Medical Observation rate, a revenue neutral rate adjustment, or realignment, should be performed that "converts" the new tiered SDS rate.
  - ◇ The new SDS rate should reflect any requirements for recovery of invasive radiology procedures, including the six hour minimum recovery.

Proposal:
Denials for Medical Necessity

- As part of the ODS system conversion, inpatient denials for medical necessity should be excluded from CPC.
  - The industry proposed system conversion should have a significant impact on this matter, by significantly reducing the denials.
- Two changes should occur:
  - To accurately compare time periods, denials for medical necessity should be extracted from the Charge per Case base period.
  - Denials should be then excluded from the current period, in conjunction with the previously outlined payment changes for ODS cases.
- These changes will provide the appropriate payments for observation services, fostering enhanced use of observation and prospective utilization review.

Proposal:
Effective Date, Conversion Review

- The system changes should be effective July 1, 2010.
- It is imperative that all system changes be addressed together, as each piece is part of a complex conversion of the payment system.
- The FY2011 Charge per Case Targets and CMI should be rebased at the same time to "level" the payments for ODS cases. The outpatient rate structure changes (Medical Observation and SDS) should also occur at the same time.
  - ◇ The FY2011 Charge per Visit (CPV) target methodology may require adjustments in conjunction with these rate conversions.
- Although this does not address hospitals' immediate concerns, a mid-year change of this magnitude is impractical.
- Similar to past rate conversions, hospitals and Staff should monitor implementation over a three year period to assure hospitals receive no more, or less revenue than appropriate.

Summary:

- The HSCRC's rate setting system should align payments appropriately, by:
  - Reducing inpatient payments for ODS cases and adjusting inpatient payments for other cases
  - Modifying outpatient charge structures to align charges with resource use and underlying costs
  - Eliminating the effect of the CMI Governor for appropriate and necessary movement of ODS cases to observation
- These changes address the system as a whole, adjusting and realigning revenues based on underlying costs in an effective manner.
- Similar to past "rate conversions," a comprehensive system conversion should occur to realign revenues and costs in a revenue neutral manner.

Appendix

Appendix A-1:
Financial Impact of Shifting 25% of ODS Cases to Outpatient Revenue Authority

Base Assumptions			
Hospital Admissions		754,953	A
Hospital CMI		1.0000	B
Hospital CPC			
Hospital CPC Revenue	$	10,779	C
	$	8,138,006,383	D = A*C
One Day Stay Conversion to Outpatient Observation			
25% of ODS Admissions		40,476 (1)	E
CPC CMI (Cases LOS = 0 or 1)		0.8251 (1)	F
CPC Revenue Authority	$	7,561	G = C*F
CPC Revenue Decrease	$	(306,056,378)	H = E*G
Outpatient Observation Visits		40,476	I
Oupatient "Per Visit" Payment		5,181	J
Outpatient Revenue Authority	$	209,688,946	K = I * J
Revenue Impact: CPC Decrease, net of CPV Increase	$	**(96,367,432)**	L = H+K
CMI Governor Impact		**(51,119,151)**	M
Total revenue impact	$	**(147,486,583)**	N = L+M

Notes:

(1): Assumes 25% reduction in ODS cases, using average CMI and CPC.

Appendix A-2:
Financial Impact of Shifting 25% of ODS Cases to Outpatient
CMI Governor

Base Assumptions			
Inpatient Admissions		754,953	A
Inpatient CMI		1.0000	B
Inpatient CPC	$	10,779	C
One Day Stay Conversion to Outpatient Observation			
Inpatient Admissions converted to observation		40,476	D
Inpatient CMI		0.8251	E
Inpatient Observation Cases adjusted for Observation		714,477	F = (A-D)
Inpatient CMI as a result of Observation Shift		1.010	G = ((A*B) - (D*E))/F
Inpatient CMI Increase as a result of observation shift		1.0%	H = G/B -1
Allowable CMI Change @ 33% Governor		**0.3%**	I = H*0.33
Remaining Inpatient CPC w/ CMI Governor	$	10,815	J = C*(1+I)
Remaining Inpatient CPC w/o CMI Governor	$	10,886	K = C*(1+H)
Inpatient Revene Base adjusted for Observation, w/ CMI Governor	$	7,726,873,939	L = J*F
Inpatient Revene Base adjusted for Observation	$	7,777,993,090	M = K*F
CMI Governor Impact	**$**	**(51,119,151)**	N = L-O

Appendix B-1:
Example of Option 1 – 25% Reduction in ODS Cases in Current Period

	Statewide Impact		
	Base Period	Current Period: 25% I/P ODS Cases to OBS	
Base Assumptions			
Hospital Admissions	754,953		
Hospital CMI	1.00		
Hospital CPC	$ 10,779		
Hospital CPC Revenue	$ 8,138,006,383		
ODS Cases (Exclude from CPC)			
Inpatient ODS Admission	161,904	121,428	75% of ODS Cases remain I/P Excluded
Inpatient ODS Case Weight	0.8251	0.825	
Inpatient ODS "Actual" Charge per Case	$ 5,181	$ 5,181	"Actual" Charge payment received
ODS "Excluded Revenue"	$ 838,755,784	$ 629,066,838	
"Rebased" CPC			
Cases	593,049	593,049	Assumes no change in included CPC volume
Rebased CPC	$ 12,308	$ 12,308	
CPC Charges	$ 7,299,250,599	$ 7,299,250,599	
Base CPC			
Inpatient CMI	1.00	1.00	No effect on CMI if ODS cases excluded from base and current period
Total Inpatient Revenue			
Cases	754,953	714,477	Included (CPC) + Excluded (ODS) Cases
Charges	$ 8,138,006,383	$ 7,928,317,437	
Outpatient			
Outpatient Cases		40,476	25% of ODS Cases moved to outpatient
Outpatient "Charge per Visit"		$ 5,181	Assumes same level of inpatient charges
Outpatient revenue increase		$ 209,688,946	(e.g. same cost to deliver service)
Total Revenue	**$ 8,138,006,383**	**$ 8,138,006,383**	

Appendix B-2:
Example of Option 1 – Impact on Case Weights

- Examples of case weight rebasing:

Current Case Weight Structure

APR DRG	Description	Cases LOS = 0 or 1			Cases = LOS 2+			Total Cases			
		Cases	Charges	Actual CPC	Cases	Charges	Actual CPC	Cases	Charges	Actual CPC	Case Weight
203	Chest Pain	10,398	$ 35,399,070	$ 3,404	3,686	$ 22,697,640	$ 6,158	14,084	$ 58,096,710	$ 4,125	0.3827
175	PTCA w/o AMI	6,910	$ 90,699,527	$ 13,126	2,693	$ 59,182,118	$ 21,976	9,603	$ 149,881,645	$ 15,608	1.4479
	All Cases	161,904	$ 838,755,784	$ 5,181	593,049	$ 7,299,250,599	$ 12,308	754,953	$ 8,138,006,383	$ 10,779	1.0000

Proposed Case Weight Structure

APR DRG	Description	Cases LOS = 0 or 1			Cases = LOS 2+			Total Cases			
		Cases	Charges	Actual CPC	Cases	Charges	Actual CPC	Cases	Charges	Actual CPC	Case Weight
203	Chest Pain	-	$ -	$ -	3,686	$ 22,697,640	$ 6,158	3,686	$ 22,697,640	$ 6,158	0.5003
175	PTCA w/o AMI	-	$ -	$ -	2,693	$ 59,182,118	$ 21,976	2,693	$ 59,182,118	$ 21,976	1.7855
	All Cases	-	$ -	$ -	593049	$ 7,299,250,599	$ 12,308	593,049	$ 7,299,250,599	$ 12,308	1.0000

Appendix C-1:
Example of Option 2 – 25% Reduction in ODS Cases in Current Period

	Statewide Impact		
	Base Period	Current Period: 25% I/P ODS Cases to OBS	
Base Assumptions			
Hospital Admissions	754,953		
Hospital CMI	1.00		
Hospital CPC	$ 10,779		
Hospital CPC Revenue	$ 8,138,006,383		
ODS Cases			
Inpatient ODS Admission	161,904	121,428	75% of ODS Cases remain CPC
Inpatient ODS Case Weight	0.4806	0.4806	Adjusted ODS weight
Inpatient ODS "Actual" Charge per Case	$ 5,181	$ 5,181	
ODS "Excluded Revenue"	$ 838,755,784	$ 629,066,838	
Non ODS Cases			
Cases	593,049	593,049	Assumes no change in non-ODS Cases
CMI	1.1418	1.1418	
Rebased CPC	$ 12,308	$ 12,308	
CPC Charges	$ 7,299,250,599	$ 7,299,250,599	
Base CPC			
Total Inpatient Revenue			
Cases	754,953	714,477	Total CPC Cases
CMI	1.00	1.0294	CMI Increase would require adjustment
Rebased CPC	$ 10,779	$ 11,097	to CMI Governor
CPC Charges	$ 8,138,006,383	$ 7,928,317,437	
Outpatient			
Outpatient Cases		40,476	25% of ODS Cases moved to outpatient
Outpatient "Charge per Visit"		$ 5,181	Assumes same level of inpatient charges
Outpatient revenue increase		$ 209,688,946	(e.g. same cost to deliver service)
Total Revenue	**$ 8,138,006,383**	**$ 8,138,006,383**	

Appendix C-2:
Example of Option 2 – Impact on Case Weights

- Examples of case weight adjustments:

Current Case Weight Structure

APR DRG	Description	Cases LOS = 0 or 1			Cases = LOS 2+			Total Cases			
		Cases	Charges	Actual CPC	Cases	Charges	Actual CPC	Cases	Charges	Actual CPC	Case Weight
203	Chest Pain	10,398	$ 35,399,070	$ 3,404	3,686	$ 22,697,640	$ 6,158	14,084	$ 58,096,710	$ 4,125	0.3827
175	PTCA w/o AMI	6,910	$ 90,699,527	$ 13,126	2,693	$ 59,182,118	$ 21,976	9,603	$ 149,881,645	$ 15,608	1.4479
	All Cases	161,904	$ 838,755,784	$ 5,181	593,049	$ 7,299,250,599	$ 12,308	754,953	$ 8,138,006,383	$ 10,779	1.0000

Proposed Case Weight Structure

APR DRG	Description	Cases LOS = 0 or 1			Cases = LOS 2+			Total Cases				
		Cases	Charges	Actual CPC	Cases	Charges	Actual CPC	Cases	Charges	Actual CPC	ODS Weight	Non-ODS Weight
203	Chest Pain	10,398	$ 35,399,070	$ 3,404	3,686	$ 22,697,640	$ 6,158	14,084	$ 58,096,710	$ 4,125	0.3419	0.5713
175	PTCA w/o AMI	6,910	$ 90,699,527	$ 13,126	2,693	$ 59,182,118	$ 21,976	9,603	$ 149,881,645	$ 15,608	1.2177	2.0387
	All Cases	161,904	$ 838,755,784	$ 5,181	593,049	$ 7,299,250,599	$ 12,308	754,953	$ 8,138,006,383	$ 10,779	0.4806	1.1418

Final Recommendation:

The Establishment of Guidelines for the Nurse Support Program II

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.

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

HEALTH SERVICES COST REVIEW COMMISSION
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TO: **Commissioners**

FROM: **Legal Department**

DATE: **December 4, 2009**

SUBJECT: **Hearing and Meeting Schedule**

Public Session

December 9, 2009	**Time to be determined, 4160 Patterson Avenue, HSCRC Conference Room**
January 13, 2010	**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