HEALTH SERVICES COST REVIEW COMMISSION
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Memorandum

URGENT

May 12, 2010

To: Chief Financial Officers

From: Robert Murray – Executive Director

Re: Education Session – Establishing an Observation Center Rate

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As you know, effective July 1, 2010, every Maryland acute hospital will be required to have an Observation (OBV) rate. The data required to be submitted by hospitals to establish this new center are due in the HSCRC's offices on or before June 1, 2010. The purpose of this memorandum is to invite representatives of all acute hospitals to participate in an educational session to assist them in identifying the data to be submitted to establish the new OBV rate center at their hospital. The session will be held on Friday May 21, 2010 at 1:00 p.m. at the HSCRC offices, 4160 Patterson Avenue. Those wishing to participate by telephone may call in at 410-764-8787.

At this session, HSCRC staff, with the assistance of Brett McCone of KPMG, will go over in detail the methodologies to be utilized and the data necessary to establish the new rate OBV center (see attachments).

In addition, the methods and the data required to modify hospitals' Same Day Surgery (recovery) rates in order to accommodate the migration of more intense surgical cases from inpatient to outpatient will be discussed.

If you have any questions concerning the above, you may contact Dennis N. Phelps, Associate Director-Audit & Compliance, at 410-764-2605.

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Memorandum

To: Chief Financial Officers

From: Dennis N. Phelps – Associate Director, Audit & Compliance

Date: April 29, 2010

Re: Establishment of an Observation Rate Center for Medical Observation Cases and Conversion of Same Day Surgery Rate Center

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The purpose of this memorandum is to notify hospitals of the process for establishing an Observation (OBV) rate center and the process to for converting their Same Day Surgery (SDS) rate effective July 1, 2010. The information needed to develop the OBV rate center and for the SDS conversion must be received in the HSCRC's offices on or before June 1, 2010, in conformance with the details stated below.

Overview

The purpose of OBV is to determine whether or not a patient should be admitted to the hospital as an inpatient. The decision to provide OBV should be solely a medical decision. OBV must be ordered and documented in writing by a medical staff practitioner. OBV services include the use of a hospital bed and periodic monitoring by nursing or other hospital staff in order to evaluate the patient's condition. Because of the nature of OBV, patients may enter through the Emergency Department (EMG) or may be directly admitted to OBV from a physician's office. OBV may be provided in a distinct unit or at any location within the hospital.

There is currently a way to charge for OBV, i.e., the costs associated with observation services are compiled in EMG, and OBV is charged as EMG services (one hour of OBV services equals 1.5 EMG RVUs). However, because reducing one-day cases will result in the provision of more outpatient observation cases, the HSCRC has decided, at the suggestion of the hospital industry, that a separate and distinct OBV rate center should be established effective July 1, 2010.

Because one-day cases will be removed from the Charge per Case (CPC) system, the need to project how many one-day cases will become OBV visits in the future and to remove revenue and days from routine centers in setting up the OBV rate center has been eliminated. The most important issue in developing the OBV rate center is setting the OBV rate since, in most cases, the actual cost of an hour of OBV services will not be known until a full year's cost data are available.

Establishing a OBV Rate Center

The inconsistency in use of OBV services among Maryland hospitals dictates that there needs to be more than one methodology for the creation of the OBV rate center. For the purposes of establishing the OBV rate center, all hospitals fall into two general categories: 1) all hospitals that have been providing and charging for OBV services, i.e., they have been generating EMG units and revenue for OBV services; and 2) all hospitals that have not been providing OBV services or have been providing OBV services but not charging for them. Below you will find the methodology to be used in each case, with variations within each category. In addition, you will find the information that must be submitted in order to establish your hospital's new OBV rate center. In the new OBV rate center, 1 hour equals 1 OBV RVU.

METHODOLOGIES

Category 1 - Hospitals that have been providing and charging for OBV services - (**Generating EMG units and revenue for OBV services.)**

Sub-categories:

A. Hospitals charging for OBV with all OBV costs in the EMG rate center (having accurately allocated OBV costs from routine centers):

1) Allocate OBV costs from EMG rate center based on EMG unit costs (unless there is a cost finding) and allocate OBV hours from EMG at 1 OBV hour

2) times 1.5 EMG RVU;

B. Hospitals charging for OBV that did not appropriately allocate all costs to EMG rate center:

1) Allocate new OBV units from EMG rate center (EMG RVUs times 1.5).

2) Allocate costs from EMG and routine rate centers based on cost finding **or allocate from both EMG and routine rate centers based on Hospital's Medical/Surgical (MSG) cost per unit (patient day)divided by 24.**

3) **Information to be provided to HSCRC: the rationale and supporting data for cost and unit of services reallocations, and a revised FY 2009 Schedule M so that the rate centers can be RATE REALIGNED in the IAS/PVPPI process.** New CPC and Charge per Visit (CPV) targets will be established based on the underlying costs.

The first year after creation of new OBV rate:

At same volumes, Hospital will generate less revenue in its EMG rate center and, if applicable, its routine centers based on allocation of costs; it will generate new revenue in OBV rate center.

Reconciliation of OBV rate to actual cost first year after creation of new OBV rate:

When FY 2011 cost data are available, determine whether FY 2011 OBV revenue generated is appropriate by comparing direct cost per actual OBV unit to direct cost per unit used to establish OBV rate. If OBV rate was either understated or overstated, a onetime revenue adjustment will be made to the Hospital's total rate base before rate realignment.

Category 2 - Hospitals that have not been providing OBV services or have been providing OBV services but not charging for them. **(No new revenue has been generated by OBV services. Rate centers where OBV costs have been reported have been overstated - - other rate centers understated)**:

1) In the absence of any historical data, the hospital's MSG rate divided by 24 should be used to set the OBV rate at a volume of 1.

2) **Information to be provided to HSCRC:** the rationale and supporting data for setting the OBV rate at other than the Hospital's MSG rate divided by 24. The new OBV rate can be established at the end of the Hospital's IAS/PVPPI process, since no volume or revenue is used to determine the new OBV rate, and the new rate will not affect the CPC and CPV targets.

First year after creation of new OBV rate center:

At same volumes, the Hospital will generate the same CPC revenue; however with the expected decreases in inpatient volumes, the routine centers will generate less revenue and CPC will have fewer cases, while generating new revenue in the OBV center.

Reconciliation of OBV rate to actual cost first year after creation of new OBV rate:

Use same methodology as in Category 1.

Surgical Cases – Same Day Surgery Recovery Services

The current structure of the Same Day Surgery (SDS) rate center is a fixed "per visit" charge per case for every outpatient surgical case. As part of the Commission's initiative to reduce the number of one-day stay cases, including surgical cases, more difficult cases will migrate from inpatient to outpatient. In order to allow for more appropriate matching of resource use to charges, the SDS rate must be tiered.

1) The Commission has decided to permit the SDS rate to be tiered. Hospitals will be required to tier their SDS based on a reasonable matching of resources utilized to the rate charged. If the recovery costs for outpatient surgical cases have not been appropriately allocated to the SDS rate center, costs may be allocated to SDS from other rate centers.

2) **Information to be provided to HSCRC: the supporting data for cost reallocations, and a revised FY 2009 Schedule M so that the rate centers can be RATE REALIGNED in the IAS/PVPPI process.**

Reconciliation of SDS rate to actual cost first year after conversion of SDS rate:

When FY 2011 cost data become available, determine whether FY 2011 OBV revenue generated is appropriate by comparing direct cost per actual SDS visit to the direct cost per SDS visit used to establish the SDS rate. If SDS rate was either understated or overstated, a one time revenue adjustment will be made to the Hospital's total rate base before rate realignment.

If you have any questions about the category that your hospital belongs in or technical questions about the methodologies, you may call me, Rodney Spangler or Chris O'Brien at 410-764-2605.