HEALTH SERVICES COST REVIEW COMMISSION
4160 PATTERSON AVENUE · BALTIMORE, MARYLAND 21215
Phone: 410-764-2605 Fax: 410-358-6217
Toll Free: 1-888-287-3229
www.hscrc.state.md.us

462nd MEETING OF THE HEALTH SERVICES COST REVIEW COMMISSION

PUBLIC SESSION OF THE
HEALTH SERVICES COST REVIEW COMMISSION
November 4, 2009
9:30 a.m.

1. **Review of the Public Minutes of October 14, 2009**
2. **Executive Director's Report**
3. **Docket Status – Cases Closed**

   2041A – Johns Hopkins Health System
   2045A – MedStar Health
   2046A – Maryland Physicians Care
   2047A – University of Maryland Medical Center
   2048A – University of Maryland Medical Center
   2049A – Johns Hopkins Health System

4. **Docket Status – Cases Open**

   2050A – University of Maryland Medical System
   2051A – John Hopkins Health System
   2052A – MedStar Health

5. **Draft Recommendation on One Day Length of Stay Policy**
6. **Draft Recommendation for Revision of the Relative Value Unit Scale of Labor and Delivery**
7. **Legal Report**
8. **Hearing and Meeting Schedule**

H.S.C.R.C's Current Legal Docket – Status (Open)
as of October 26, 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	10/07/09	N/A	N/A	ARM	DNP	OPEN
2051A	John 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

Proceedings requiring Commission action – Not on OPEN Docket: None

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

Health Services Cost Review Commission
November 4, 2009

This document represents a draft recommendation to be presented to the Commission on November 4, 2009. Comments on this recommendation should be directed to Robert Murray, Executive Director of the HSCRC, by Wednesday, December 2nd, 2009.

Introduction

This recommendation relates to potential changes in rate incentives associated with so-called one-day length of stay ("one-day LOS ") cases reimbursed through the Maryland rate setting methods as determined by the Health Services Cost Review Commission ("HSCRC"). 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.

Background

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 or other less-intensive (and less costly – from Medicare's perspective) forms of care. One-day LOS cases by 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 an anomalous reporting and handling (for purposes of hospital Charge per Case development) 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 factors 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 (relative to national standards) 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 phenomena. **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%

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. Treating patients on an outpatient

observation basis is both less costly (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 believe that both the currently handling of denied cases and the potential for generating so-called "rate-capacity" on denied and non-denied one-day cases, does indeed created too strong of a financial incentive for Maryland hospitals to admit short stay (most predominantly one-day LOS cases).

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 anomaly in the way in which denied admissions (a majority of which are likely one-day stay cases) are handled in the HSCRC's Charge per Case (CPC) system. 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 for these cases on an inpatient basis.[1] Although hospitals do not receive payment for inpatient services on these denied cases, under the HSCRC's unique CPC revenue constraint system, hospitals have received full "DRG-weight" credit for these cases. Thus, while a facility may not be paid for a specific denied case, the presence of this case in the HSCRC's financial data reports allows the hospital to claim credit for the case's full DRG weight for the purposes of determining that facility's approved inpatient revenue for that year. In essence, even though actual payment was denied for a case (because it did not meet medical necessity criteria), the hospital still effectively receives full average DRG rate credit for that case under the CPC.

Appendix I to this recommendation provides an example of how the hospital still receives "payment" for a denied case, by being able to raise its rates to all other payers by an amount associated with the "DRG-credit" it receives, associated with the denied case.

Staff believes that in cases that have been denied based on a medical necessity determination, it should not have the ability to recoup these lost amounts by charging higher rates to all payers.

Creation of "Rate Capacity" on non-denied One-day LOS Cases

Another (but related) factor contributing to the very strong financial incentive to admit short stay patients, is the ability of hospital to generate what is referred to as "rate capacity." Under the HSCRC

[1] 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 and the hospital. The hospital will not then receive payment for inpatient services rendered on that case.

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 $7,500 per case, the hospital gets "credit" for this average DRG charge level. This credit is factored in during the year when the HSCRC staff determines the hospital's overall "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 0.75
If the average Maryland hospital case (index of 1.0) has a charge of $10,000, this hospital ultimately gets DRG "credit" of 0.75 x $10,000 = $7,500.

Thus, in this circumstance, although the hospital generated payments of $5,100 for the non-denied case, it ultimately generates the ability to raise its rates to all payers by an additional $2,400 (the difference between the average DRG weight or credit for the case and the actual payment for the specific one-day LOS case) and then generate 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." Appendix II provides a table further illustrating the generation of rate capacity for a hypothetical one-day LOS case.

Hospitals, thus, have a very strong incentive to admit short-stay cases in the Maryland system and the data provided previously shows that Maryland hospitals have been responding aggressively (relative to hospitals in other states) to this incentive.[2]

[2] 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.

The implications of these two circumstances are that: 1) payers are made to pay for cases that were deemed medically unnecessary (as shown above); and 2) Maryland hospitals have very strong incentives to admit cases that could otherwise be treated on an outpatient basis. The actual hospital cost (actual expenses incurred by the facility) of treating these cases appears to be relatively the same whether the case is admitted or treated as an observation case in the emergency department. However, under the current HSCRC CPC payment system, hospitals stand to receive three times more revenue (payments), if they admit such a patient.[3]

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 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] Average payment weights developed for the HSCRC's planned Charge per Visit Outpatient constraint system shows that outpatient observation cases carry a weight of approximately $2,500 per case compared to the approximate $7,500 average charge generated for that same case if admitted to an inpatient service.

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 V	9,534	6,890	72%	44%
198	ANGINA PECTORIS & CORONARY ATHEROSCLEROSI	9,577	5,674	59%	30%
201	CARDIAC ARRHYTHMIA & CONDUCTION DISORDEF	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 & VC	8,005	2,888	36%	
243	OTHER ESOPHAGEAL DISORDERS	4,483	2,726	61%	
513	UTERINE & ADNEXA PROCEDURES FOR NON-MALIC	5,315	2,189	41%	
140	CHRONIC OBSTRUCTIVE PULMONARY DISEASE	15,134	2,181	14%	10%
310	INTERVERTEBRAL DISC EXCISION & DECOMPRESSIC	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 HEAR	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 or 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.

Staff Observations Regarding One-day LOS Cases and Hospital Behavior

1 -Based on the evidence shown previously and based on staff's review of the dynamics of the HSCRC's current CPC payment methodology, it appears that hospitals are responding to the very strong incentives to admit short stay cases rather than treat them (if deemed medically appropriate to do so) on an outpatient basis. According to data provided by United Health Care, 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 all United Cases nationally of 36%.

2- Given these circumstances and staff discussions with CMS and RAC personnel, it is clear that Maryland hospitals are vulnerable to large numbers of denials associated with one-day stays (going back three years) from RAC audit activities. These activities are likely to become more and more 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 years 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 through a change in overall hospital financial incentives through the rate setting mechanisms of the HSCRC.

3- Staff believes the incentives in the rate system to admit short stay cases are the clearly too strong and are inducing behavior on the part of hospitals that result in excessive charging practices. A broad-based modification in these incentives by the HSCRC is clearly called for. A more holistic change in the financial incentives to change behavior and promote improved efficiency is infinitely preferable to the case by case denial and appeal process that is sure to beset Maryland with the commencement of RAC audit activities in the State later this fiscal year.

4- Current and growing budget deficits at both the State and federal levels are also placing the system under increased pressure to deliver improvements in efficiency and reduction in waste.

Given these circumstances staff is recommending two changes to its Charge per Case methodology in order to both to 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. These two mechanisms

are described in the sections that follow. There is a desire by staff to make adjustments to the incentives at a system level and to phase-in the adjustments over time.

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, hospitals 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 Adjust CPC for Denied Cases

As noted, under the HSCRC's CPC rate methodology denied cases are reported to the Commission and in the HSCRC's financial data and case mix data tape. As a result, these cases allow 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). Because of this anomaly, hospitals are 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 below shows 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.

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 remove of full DRG weights associated with denied cases will reduce hospital approved revenues by some $30-37 million annually. Hospitals can of course 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 $2,500 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.

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

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

As noted above, there is clearly too strong a set of incentives under the current CPC rate setting methodology, for hospitals to admit certain patients to an inpatient unit for one day rather than observe these patients in a less costly outpatient. Patients admitted to the hospital for one day generate 'rate capacity' because the total charge for the admission is much less than the approved revenue for the

case. 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.

The proposed approach will focus 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 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.

Table 6 shows the current rate capacity being generated by hospitals on one-day LOS cases from FY 2009.

Table 6

Rate Capacity Generated on One-Day LOS Cases

Hospital	Total Cases	Total Charges	One Day Stay Cases	One Day Stay Charges	Rate Capacity for All One Day Stay Cases	Rate Capacity per Case
Johns Hopkins Hospital	41,957	$844,076,640	9,904	$80,749,707	$38,012,876	$3,838
University of Maryland Hospital	26,096	$543,475,883	6,168	$45,519,895	$26,027,454	$4,220
Franklin Square Hospital Center	28,880	$272,084,705	8,095	$37,938,252	$19,113,381	$2,361
St. Joseph Medical Center	24,889	$281,400,571	6,231	$43,273,785	$13,685,856	$2,196
Union Memorial Hospital	19,823	$293,089,587	6,200	$54,371,934	$13,658,964	$2,203
St. Agnes Hospital	21,966	$231,617,044	4,706	$25,348,798	$12,351,923	$2,625
Sinai Hospital	26,018	$358,670,815	4,959	$34,130,067	$10,903,998	$2,199
Washington Adventist Hospital	18,714	$191,619,024	3,827	$25,560,039	$10,284,694	$2,687
Baltimore Washington MC	17,910	$181,147,424	3,946	$17,973,376	$10,067,476	$2,551
Anne Arundel Medical Center	28,784	$242,910,188	6,381	$29,701,540	$9,656,639	$1,513
Holy Cross Hospital	34,945	$269,372,398	4,589	$16,459,773	$8,826,064	$1,923
Mercy Medical Center	20,192	$195,236,188	4,367	$24,073,753	$8,580,879	$1,965
Johns Hopkins Bayview	21,080	$259,432,160	3,608	$19,025,917	$8,393,611	$2,326
Carroll Hospital Center	16,369	$137,718,673	4,209	$16,950,195	$7,229,017	$1,718
GBMC	25,280	$222,666,965	4,156	$22,302,557	$7,211,030	$1,735
Good Samaritan Hospital	16,338	$192,924,729	3,496	$16,820,378	$7,090,129	$2,028
Upper Chesapeake	16,508	$128,297,931	5,129	$23,285,073	$6,583,116	$1,284
Peninsula Regional Medical Center	22,486	$249,034,807	3,852	$23,860,254	$6,482,545	$1,683
Prince Georges Hospital Center	15,598	$166,649,193	2,723	$13,353,546	$6,363,752	$2,337
Shady Grove Adventist Hospital	25,763	$199,068,622	4,023	$16,152,751	$6,308,574	$1,568
Suburban Hospital	13,939	$154,002,137	3,590	$22,115,514	$5,992,474	$1,669
Washington County Hospital	17,163	$146,407,376	3,201	$10,614,649	$5,612,938	$1,753
Harbor Hospital Center	14,492	$137,375,124	2,959	$13,731,086	$5,504,069	$1,860
Southern Maryland Hospital Center	17,466	$141,985,254	3,318	$12,430,387	$5,427,992	$1,636
Doctors Community Hospital	11,091	$101,410,326	2,683	$8,648,865	$5,368,432	$2,001
Frederick Memorial Hospital	18,633	$155,881,749	2,453	$8,377,590	$5,091,484	$2,076
St. Mary's Hospital	10,415	$66,658,257	2,921	$9,048,981	$4,555,720	$1,560
Howard County General Hospital	16,588	$134,959,443	2,848	$11,361,164	$4,528,899	$1,590
Northwest Hospital Center	11,878	$120,494,933	2,286	$8,674,782	$4,235,788	$1,853
Memorial Hospital at Easton	10,630	$89,510,640	2,022	$8,105,502	$4,092,018	$2,024
Johns Hopkins Oncology	4,726	$148,652,552	908	$8,142,357	$4,003,371	$4,409
Harford Memorial Hospital	7,159	$55,345,177	1,966	$8,053,367	$3,631,317	$1,847
Maryland General Hospital	11,736	$129,217,173	1,706	$8,108,518	$3,614,915	$2,119
Calvert Memorial Hospital	8,619	$59,061,905	2,214	$8,321,004	$3,416,071	$1,543
Civista Medical Center	7,997	$60,963,956	1,758	$5,514,286	$3,334,055	$1,897
Union of Cecil	8,587	$64,042,303	2,193	$6,705,010	$3,219,962	$1,468
Braddock-Sacred Heart Hospital	8,982	$81,687,093	1,947	$10,584,279	$2,972,122	$1,527
Montgomery General Hospital	10,395	$89,570,908	1,551	$6,126,687	$2,806,746	$1,810
Memorial of Cumberland	8,228	$67,351,089	1,304	$4,408,182	$2,608,373	$2,000
Laurel Regional Hospital	6,520	$53,172,784	994	$4,069,614	$1,886,450	$1,898
Chester River Hospital Center	3,425	$28,459,719	692	$2,275,772	$1,471,124	$2,126
Dorchester General Hospital	3,384	$27,205,612	561	$1,638,997	$1,416,771	$2,525
Atlantic General Hospital	3,386	$34,379,416	670	$2,588,950	$1,248,682	$1,864
Garrett County Memorial Hospital	2,568	$17,386,757	751	$2,088,943	$1,009,578	$1,344
Bon Secours Hospital	6,375	$70,330,588	734	$3,734,763	$993,705	$1,354
Sinai Hospital Oncology	1,513	$26,950,956	194	$963,748	$824,631	$4,251
Fort Washington Medical Center	2,701	$21,936,471	546	$1,977,259	$778,845	$1,426
Univ MD Oncology	1,261	$37,422,208	84	$431,861	$343,542	$4,090
James Lawrence Kernan Hospital	2,578	$45,144,917	114	$744,588	$334,549	$2,935
McCready Memorial Hospital	564	$5,404,412	122	$508,364	$207,768	$1,703
Totals	722,595	$7,832,864,782	149,859	$786,946,659	$327,364,372	$2,184

Operational Issues

Treatment of Denied Cases and One Day Stay Penalty in CPC Settlement

When calculating each hospital's charge per case compliance for fiscal year 2010, the staff will need to make the following adjustments. These adjustments are meant to treat denied cases as if they never existed and penalize hospital for excess one day stay cases:

1) staff will identify the denied cases from data provide by each hospital to the Commission;
2) staff will remove these cases and actual charges associated with these cases from the case mix tape;
3) staff will recalculate the hospital's case mix index based on remaining revenue and cases;
4) the revised case mix index will be used to adjust each hospital approved CPC target;
5) the adjusted CPC target will be multiplied by the number of cases to arrive at approved revenue allowed under the CPC;
6) the staff will apply a penalty for the estimated excess rate capacity included in the approved revenue allowed under the CPC. This will result in the final approved revenue allowed under the CPC;
7) staff will remove the actual denied cases and the associated charges from the financial data used to calculate the final CPC reward or penalty;
8) staff will remove the actual units and revenue from the approved revenue for the following year.

Figure 2 below provides an example of the proposed handling of denied cases under this proposal.

Figure 2

Denied Cases - Proposed Treatment under the CPC

Example Casemix Data	Approved Cases	Associated Revenue	Actual Charge	Target	CMI	CMI Wgts
Total	5,000	$50,000,000		$10,000	1.00	5000
Remove:						
Denied Charges Incl on Tape	100	$500,000	$5,000	$7,500	0.75	75
Revised Total	4,900	$49,250,000		$10,051	1.0051	4925

CPC Settlement FY 2010		
Revised Approved CPC	$49,250,000	($10,000/1.000*1.0051*4,900)
Excess One Day Stay Penalty	($700,000)	
Final Approved CPC Revenue	$48,550,000	
Charges fr Financial Data	$50,000,000	
Removed Revenue for Denied	($500,000)	
Actual Revenue under CPC	$49,500,000	
Savings(Dissavings)	($950,000)*	
		Net
Hospital Receives	$48,550,000	$48,550,000
Denied Revenue	$500,000	$0
Total Approved Revenue	$49,050,000	$48,550,000

*Differnce Between $7,500 per Case Received under CPC and Actual $5,000 per Case Charged and One Day Stay Penalty

Hospital Charging Capability for Observation Cases

During staff's discussions with hospital representatives regarding one-day LOS cases, questions have 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.

The description of Observation ("OBS") services and instructions how to charge for OBS are included in Emergency Services – Standard Unit of Measure References – Appendix D and summarized below in **Figure 3**. 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 3

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. Some allowance for this case mix impact may be appropriate.

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 does have negatively contribute 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 Medicare waiver test (which based on a comparison of per case payments – Maryland vs. the US) been more favorable due to Maryland's higher proportion of short stay cases and thus lower overall payment per case. Any policy change that cause hospitals to shift one-day LOS cases out of the inpatient setting, may well increase

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 treat 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 7 provides a preliminary projection of a worst case impact on our waiver test after full implementation (two – three years) of the proposed policy changes.[4]

Table 7

Worst Case Impact on Medicare Waiver

	Maryland Medicare Pmt per case	Cumulative Growth since 1981	US Estimate with Medicare Pmt per case (2)	Cumulative Growth since 1981	Relative	Techinical Cushion	Waiver Test Correction (3)(4) (5)
Waiver Base Year pmts (base 1981)	$2,972		$2,293				
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

[4] 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 (penalties)). Also, hospitals nationally are expected to also 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).

Recommendation:

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 hospitals 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. Also for the full rate year FY 2010 (effective July 1, 2009) 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.

Appendix I

Example of how Hospitals get CPC "Credit" for Denied Cases

Case 1 Has an actual itemized "Charge" of $5,100

Case 1 is ultimately assigned to DRG 100

All cases assigned to DRG 100 - get a case DRG weight of 0.75

If the Average Case in Maryland - $10,000

The Average Case has an index weight of 1.00

Cases with a DRG case weight of 0.75 - get overall "revenue credits" (or Charge Capacity) in the HSCRC system of $7,500

If the hospital was denied actual payment, for this Case 1 by a payer or " self-denied" but the hospital's medical UR committee, the hospital's CPC approved revenue would still include in it a "credit" associated with a DRG weight of 0.75.

Accordingly the hospital would have the ability to ineffect charge that denied $5,100 amount and an additional $2,400 (associated with the $7,500 average DRG weight) to all payers through high unit rates during the course of the same year.

Example of Charges vs. Rate Capacity

Case 1 Has an actual itemized "Charge" of $5,100

Case 1 is ultimately assigned to DRG 100

All cases assigned to DRG 100 - get a case DRG weight of 0.75

If the Average Case in Maryland - $10,000

The Average Case has an index weight of 1.00

Cases with a DRG case weight of 0.75 - get overall "revenue credits" (or Charge Capacity) in the HSCRC system of $7,500

So even though the hospital charged only $5,100 - they get their revenue base adjusted upward by $7,500 for each case in DRG 100

STAFF RECOMMENDATION

November 4, 2009

The Commission staff recommends for review and public comment 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.

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 are 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:
Amniocentesis	3
Biophysical Profile	5
Central Line Placement	2
Cervical Cerclage	10
Dilation & Curettage (D & C)	9
Dilation and Evacuation (D & E)	9
Doppler Flow Evaluation	1
External Cephalic Versions	10
Electronic Fetal Monitoring	1 per hour
Minor Surgery Short stay w/o Delivery (wound care, I&D, Bartholin Cyst treatment, cerclage removal)	9
Non Stress Test	5
Oxytocin Stress Test	5
Periumbilical Blood Sampling (PUBS)	18 (+ 4 w/multiples)
Periumbilical Blood Sampling (PUBS) double set up w/OR	2
Scalp PH, fetal	1
Spinal headache treatment	2

Ultrasound, OB (read by Obstetrics only) 3

APPENDIX D
STANDARD UNIT OF MEASURE REFERENCES

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

OBSTETRICAL ADD ON TO DELIVERY PROCEDURES:

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

MISCELLANEOUS PROCEDURES	RVUs:
Newborn Audiology: Auditory Brainstem Response (ABR)	1
Newborn Audiology: Otoacoustic Emission Screen (OAE)	1
Oocyte Retrieval	10
Gamete Intrafallopian Tube Transfer (GIFT)/Tubal Embryo Transfer(TET)	16

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:**
Outpatient Maternal/Fetal Observation:	1 per hour

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:**
Admitted inpatients: (<u>Max = 28 RVUS per day)</u>	**2/hour****
Non-admitted patients (<u>Max = 48 RVUS per day)</u>	**2/hour**

****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.

<u>Diagnoses:</u>
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

STATE OF MARYLAND

HEALTH SERVICES COST REVIEW COMMISSION
4160 PATTERSON AVENUE · BALTIMORE, MARYLAND 21215
Phone: 410-764-2605 Fax: 410-358-6217
Toll Free: 1-888-287-3229
www.hscrc.state.md.us

TO: **Commissioners**

FROM: **Legal Department**

DATE: **October 30, 2009**

SUBJECT: **Hearing and Meeting Schedule**

Public Session

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

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

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Donald A. Young, M.D.
Chairman

Kevin J. Sexton
Vice Chairman

Joseph R. Antos, Ph.D.

Trudy R. Hall, M.D.

Steven B. Larsen, J.D.

C. James Lowthers

Herbert S. Wong, Ph.D.

HEALTH SERVICES COST REVIEW COMMISSION
4160 PATTERSON AVENUE · BALTIMORE, MARYLAND 21215
Phone: 410-764-2605 Fax: 410-358-6217
Toll Free: 1-888-287-3229
www.hscrc.state.md.us

Robert Murray
Executive Director

Stephen Ports
Principal Deputy Director
Policy & Operations

Gerard J. Schmith
Deputy Director
Hospital Rate Setting

Charlotte Thompson
Deputy Director
Research and Methodology

Calendar Year 2010 Commission Meeting Schedule

January 13, 2010

February 3, 2010

March 3, 2010

April 14, 2010

May 5, 2010

June 9, 2010

July 7, 2010

August 4, 2010

September 1, 2010

October 13, 2010

November 3, 2010

December 8, 2010