

AGREEMENT BETWEEN THE HEALTH SERVICES COST REVIEW COMMISSION AND
_____ HOSPITAL
REGARDING THE ADOPTION OF THE TOTAL PATIENT REVENUE SYSTEM

This Agreement made this ____ day of _____, 2010, between _____ HOSPITAL (the “Hospital”) and the HEALTH SERVICES COST REVIEW COMMISSION (the “Commission” or “HSCRC”) is subject to the following provisions:

I. General Description

The Total Patient Revenue system (“TPR”) is a revenue constraint system developed by the Maryland Health Services Cost Review Commission which provides hospitals with a financial incentive to manage their resources efficiently and effectively in order to slow the rate of increase in the cost of health care. The TPR also is consistent with the hospital’s mission to provide the highest value of care possible to the community it serves.

TPR revenue constraint systems are available to sole community provider hospitals and hospitals operating in regions of the State characterized by an absence of densely overlapping services areas. The HSCRC staff reserves the right to exclude any hospital from eligibility for the TPR if it determines that that hospital’s service area characteristics are not conducive to successful implementation and operation of the TPR constraint system.

The basic concept embodied in the TPR constraint system is the assurance of a certain amount of revenue each year, independent of the number of patients treated and the amount of services provided to these patients. The hospital therefore has the incentive to reduce length of stay, ancillary testing, unnecessary admissions and readmissions, as well as improve efficiency in the provision of services while treating patients in the most economical manner consistent with appropriate, high quality medical care.

II. Methodology

A. Revenue Covered by the Agreement and Contract Period

The TPR shall be applicable to all HSCRC rate regulated inpatient and outpatient services and revenues of _____ Hospital. A **Total Patient Revenue Constraint** (encompassing all permanent and one-time revenues as determined by the Hospital’s approved Rate Order) will be established. To meet this overall TPR Constraint, the Hospital may seek to manage its utilization and pricing of the services covered by the Agreement. The program will be in effect for three years, beginning July 1, 2010 and ending June 30, 2013.

B. General Methodology

A **Base Year** is established (usually the most recent fiscal year). These base patient revenues will be adjusted for price variance from approved rates, for volume variances, changes in differential due to changes in payer mix and any other approved **One-Time adjustments**. This base year revenue is then

adjusted for any special transitional revenue provision to facilitate conversion of the hospital from an 85% variable cost system to a 100% fixed cost system (as is applicable under the TPR constraint system).¹ This provision is described in subsection C. In year three of this agreement, the hospital is also eligible for a population adjustment to its overall TPR constraint. The hospital then must provide appropriate and necessary hospital services to its patient population and operate within the TPR constraint afforded it by the HSCRC for all years this agreement remains in effect.

C. Special Provisions for Transitioning to the TPR Methodology

In addition to the compliance and adjustment provisions noted above and detailed in section III below, the Hospital will receive a pre-determined Transitional Revenue Provision as a proxy for the hospital's service area population change and community service requirements in years one and two of this agreement. This adjustment will be based upon the average ungoverned case mix growth for the previous three rate years, plus 100% of the average volume growth for the previous three rate years. A "rate year" begins on July 1 and concludes on June 30 of the following year. A proportion of this transitional adjustment will be applied to the Hospital's permanent revenue base rate years 2011 and 2012. For rate year 2013, the hospital will receive the agreed-upon provision to adjust for the impacts of population growth on service demands at the hospital.

III. Computation and Application of the TPR

A. Compliance Monitoring Under the TPR

One of the goals of the TPR is to reduce the burden of regulation on hospitals. Thus, the unit rate compliance corridors generally applied to hospitals will be relaxed. The Hospital will be free to charge at a level up to 5% above the approved individual unit rates without penalty. This limit can be extended to 10% for all rate centers at the discretion of the Commission staff upon presentation of evidence by the Hospital that it would otherwise not achieve the approved total revenue for the year. Similarly, there will also be a 5% corridor on undercharging. This corridor may also be expanded to 10% for all revenue centers if the Hospital can substantiate that its revenue constraint will be exceeded without this flexibility.

B. Calculation of TPR Revenue Constraint

In future years, the Hospital will be subject to rate adjustments necessary to bring it in compliance with the approved TPR Revenue Constraint (a **Cap Adjustment**). If the gross revenue charged by the Hospital exceeds the approved revenue, the difference between the gross revenue charged and the approved revenue will be subtracted from the revenue that would otherwise have been approved for the Hospital for the subsequent year. Conversely, if the gross revenue charged is less than the approved revenue, the difference will be added to the revenue for the subsequent year, except that undercharges below the corridor specified in subparagraph A above will not be so included.

C. Annual Adjustments

The following adjustments to the approved combined total revenue shall be made to arrive at the approved combined total revenue for the subsequent year:

¹ This Transitional Revenue Provision is only applicable for hospitals newly converting from the Commissions Charge per Case 85% variable system to the TPR.

1. Adjustment for the annual update factor approved by the Commission²;
2. Adjustment for population changes, the scope and data source(s) defined in Appendix A of this agreement. The adjustment for population growth, as defined in Appendix A, shall be limited to 25% of the change in population or 1%, whichever is less;
3. Reversal of any previous retroactive adjustments;
4. Differential readjustment due to changes in mix of payers or changes in approved differential amounts and bad debt;
5. Any required Cap Adjustment as specified in subparagraph B above.

It is anticipated by the HSCRC and the Hospital that the TPR will be in place for at least three years in order to provide a stable planning environment for the Hospital.

D. Exclusions and other Modifications

Prior Year Outlier Cases: The Hospital's approved TPR Constraint will be inclusive of any case outlier payments as previously defined and applied to the Hospital's Base Year revenue.

Exemption from any application of a State-wide Readmissions Policy: Because this agreement represents an aggressive attempt to reduce readmissions, the terms of this agreement will supersede any State-wide policy to reduce readmissions such as the planned mandatory State-wide implementation of the HSCRC's **Maryland Hospital Preventable Readmissions ("MHPR") initiative**.

Exemption from "negative scaling" related to the HSCRC's ROC: If the Hospital operates successfully under this TPR constraint, the Hospital's ROC position may be expected to erode as it reduces the number of unnecessary inpatient cases it treats and instead care for these patients on a more coordinated way through improved communication and more effective use of ambulatory services. Because this agreement substantially alters the measurements upon which hospitals are compared for relative efficiency within the State (the HSCRC's Reasonableness of Charges analysis or ROC), the Hospital will be exempt from all negative scaling on the ROC.

IV. TPR Evaluation, Monitoring, Modification and Cancellation Provisions

A. Necessary Monitoring of TPR Operation and Performance

Significant increases or decreases in the Hospital's Market Share of patients (receiving regulated hospital services) in its **Primary and Secondary Service Areas** can have materially positive or negative impacts on the efficacy of this Agreement (the Hospital's Primary and Secondary Service Areas are defined by ZIP code and presented in Appendix B to this Agreement). The HSCRC will monitor the Hospital's market share overtime by analyzing and identifying and shifts in the Hospital's patient volume from its base year Primary and Secondary service areas. Significant changes in the Hospital's market share may be the basis for a renegotiation of the Hospital's TPR constraint as

² Update factor is inclusive of quality scaling for the Commission's Quality-Based Reimbursement and Maryland Hospital Acquired Conditions

described in subsection D below.

Similarly, significant changes in the care delivery system in the Hospital's Primary and Secondary Service Areas can also positively or negatively influence the appropriateness of the Hospital's current TPR constraint. The Hospital thereby agrees to declare and describe any financial interest (or ownership) it has in non-hospital services provided within the Hospital's Primary and Secondary Service Areas, as of the effective date of this Agreement, in Appendix C. The Hospital must also inform the HSCRC of any significant future acquisitions or divestitures of non-hospital health services.³ The HSCRC may request data on the utilization of these services historically and over time to ensure that compliance with the TPR Constraint is achieved by better utilization management of existing regulated services and not through a shifting of services from the regulated to the unregulated sectors.

Hospital agrees to notify the HSCRC staff in advance or notify the HSCRC staff of any other significant changes to the care delivery system in its primary and secondary service area as a result of changes initiated by the Hospital, its affiliated providers or by other care groups not related to the hospital within 30 days of becoming aware of said developments.

Staff will also monitor the Hospital's performance on the HSCRC's core Quality of care metrics (The Hospital's overall ranking and year-to-year changes in **Quality-Based Reimbursement**, Maryland Hospital Acquired Conditions, Rates of Preventable Readmissions and a review of the Hospital's risk-adjusted Mortality.) It is expected that the Hospital will, at a minimum, maintain its relative performance ranking on the HSCRC Quality-Based Reimbursement and Maryland Hospital Acquired Conditions rankings during the course of this three year agreement.

B. Evaluation of the Effectiveness of the TPR

As described earlier in this Agreement, the primary goal of the TPR system is to provide a Hospital with strong incentives to treat its community of patients in the most efficient and clinically effective way, resulting in an improvement in the value of care provided.

After the first year of operation (and in subsequent years) of the TPR agreement, the HSCRC staff may perform an evaluation of the success of the TPR program and report back to the Commission. Success will be evaluated in the context of how well the pilot contributed to the goal of improving the overall value of care provided at the hospital (lower cost and better clinical effectiveness/quality). Particular focus will be applied to an analysis of utilization trends pre-and post-TPR implementation and evaluation of per capita hospital and total health care costs of the Hospital's Primary and Secondary Service areas. This evaluation will also summarize the performance of the Hospital on the Commission's quality of care metrics described in subsection A and any additional quality of care measurement standards developed by the HSCRC in future years.

C. Possible Modifications to Allow for Better Alignment of Incentives

Under healthcare reform, a number of approaches have been mentioned to contain healthcare costs. For example, bundling services under a single payment have been identified prominently as one method for aligning incentives for the efficient delivery of healthcare services. The methodology outlined within this document is a first step in bundling by providing a single payment for an episode of care, regardless of additional readmissions that occur after the initial admission into a hospital. Because healthcare reform

³ This would include the purchase or divestiture of physician practices, joint-venture arrangements with other providers to establish unregulated services that duplicate or could substitute for regulated services currently provided by the hospital (such as, but not limited to, unregulated clinic, urgent care, or ambulatory surgery services), or other non-hospital services.

efforts are progressing rapidly, the parties to this agreement may mutually agree to modify its terms to expand the services included within the methodology as these changes are allowed by law and/or regulation. Potential changes include the potential for gain-sharing with physicians and the potential extension of the TPR constraint to cover non-hospital services.

D. Provisions Governing Other Potential Modifications

A request to initiate a reevaluation of the revenue cap by the Hospital shall be submitted in writing to Commission staff accompanied by supporting documentation. Similarly, the HSCRC has the right to open discussions with the Hospital, regarding modifications to the TPR constraint based on its on-going review and monitoring of the Hospital's operation and service area market share. A decision to modify the revenue cap rests within the sound discretion of Commission staff, but with the caveat that the Hospital may terminate its participation in the TPR if it is unwilling to accept such a modification.

If the Hospital applies and receives approval to provide a new service to its population area, the Hospital may petition the Commission staff for an adjustment to its total revenue constraint if it can be demonstrated to the satisfaction of Commission Staff that provision of the new service cannot be managed within its existing revenue constraints. Such requests shall be evaluated by staff on a case-by-case basis. Likewise, modifications to the TPR constraint can be proposed by staff given other significant changes in the scope of regulated services provided by the Hospital.

As described above, the HSCRC staff will monitor the Hospital's market share of its Primary and Secondary Service Areas over time. If either party believes that change in market share and/or utilization is sufficient to justify reevaluation of the revenue cap, that party has the right to initiate such a reevaluation and potential modification to the hospitals TPR constraint.

E. Cancellation/Renegotiation

This contract may also be cancelled by the Hospital at the end of the three year term of this Agreement by giving the Commission 60 days written notice of intent to cancel with or without cause. The Commission reserves the right to cancel this Agreement, with cause, at any time.

V. Definition of Terms

Total Patient Revenue Constraint: The total regulated revenue for the hospital for a given rate year, documented by the hospital's Order Nisi

Base Period: The year immediately prior to the hospital converting to a TPR Constraint

Primary Service and Secondary Areas: The ZIP codes that account for 75% and 25% of the patient volume treated by the Hospital.

Price Compliance: Relaxed unit rate compliance corridors of +/- 5% for all regulated revenue centers, which may be expanded to +/- 10% with approved justification, to facilitate managing to the TPR Constraint.

Annual Update: In year one and two of this agreement, the hospitals shall receive the agreed upon transitional revenue provision, the annual update factor, and any change in markup due to changes in payer mix, approved differentials, and the bad debt provision. In year three of this agreement, the hospital

shall receive the annual update factor, change in markup, and population adjustment calculated in accordance with the methodology detailed in Appendix A of this agreement.

Cap Adjustments: Annually, the regulated revenue constraint, the approved regulated revenue for the current rate year, is compared to the actual regulated revenue charged. Any amount in excess of the revenue constraint is a one-time reduction to the revenue constraint for the subsequent rate year. Similarly, any shortfall is a one-time addition to the revenue constraint for the subsequent rate year. Once these amounts are determined, any one-time adjustment in the prior year’s regulated revenue are reversed, and the current year’s one-time adjustments are applied to establish the new revenue constraint for the new rate year.

Maryland Hospital Acquired Conditions Initiative: The HSCRC’s Hospital Acquired Condition (“HACs”) measurement methodology that compares a hospital’s risk-adjusted actual rate of HACs to an expected or predicted rate of HACs based on State-wide experience.

Quality-Based Reimbursement: The HSCRC’s Pay-for-Performance (P4P) initiative that links hospital both relative and year-to-year performance on a list of 19 processes of care measures related to Acute Myocardial Infarction, Pneumonia, Heart Failure and Surgical Infection Prevention.

Reasonableness of Charges Negative Scaling:

Maryland Hospital Preventable Readmissions Initiative: A planned P4P initiative designed to link performance on risk adjusted rates of readmissions (based on a sub-set of all-cause readmissions – as defined by the 3M Health Information System’s Potential Preventable Readmissions (“PPRs”).

Population Adjustment:

In Witness whereof, the Parties have executed this Agreement and have this date caused their respective signatures to be affixed hereto:

Attest: _____ by _____ Date _____

Chief Executive Officer

Attest: _____ by _____ Date _____

Executive Director
Health Services Cost Review Commission

Appendix A – Technical Addendum

1 – Transitional Revenue Provision Terms:

In year one, Rate Year 2011 _____% in permanent revenue totaling \$0,000,000 shall be added to the revenue constraint

In year two, Rate Year 2012 _____ % in permanent revenue totaling \$0,000,000 shall be added to the revenue constraint

2 – Population Adjustment:

The adjustment shall be calculated based on a weighted average of growth and aging of the population. The data source is _____ as published by _____. The base will be rate year 2010 and the current period will be rate year 2012.

(More hospital specific detail here)

3 – Rate Year 2011 Revenue Constraint

RY 2011 annual update newly approved permanent revenue \$

TPR year one transition incentive ___% of \$_____ \$

One-time adjustments (list all by name)

NSP I \$

NSP II \$

Rate Year 2011 Total TPR Revenue Constraint \$

(Equal to total rate order revenue)

Other technical details shown here? (Can't think of anything at the moment)

Appendix B – Hospital Defined Primary and Secondary Service Areas by ZIP Code

Appendix C – Hospital Financial Interest (or Ownership) in Non-Hospital Services Provided Within the Hospital's Primary and Secondary Service Area