DRAFT

CHARGE CORRIDORS WITHIN THE TOTAL PATIENT REVENUE AND GLOBAL BUDGET REVENUE AGREEMENTS

Health Services Cost Review Commission
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Objective

The purpose of this document is to explain the approach that the HSCRC will use to implement charge corridors for Hospitals operating under Global Budget Revenue (GBR) or Total Patient Revenue (TPR) agreements in Rate Year 2015. As HSCRC develops additional tools to measure market share changes, site of service shifts, investments in care improvement and alignment, and efficiency measures, the approach will be modified.

Overview of Unit Rate Charge Corridors

Both the TPR and GBR agreements allow hospitals to increase or decrease their approved unit rates in order to achieve the overall approved global revenue for the hospital. However, hospitals may only vary their approved unit rates within a charge corridor. Specifically, hospitals may not increase or decrease their approved unit rates by a magnitude of greater than 5% without receiving permission from the HSCRC. If permission is granted, the hospital will be allowed to expand the charge corridor to 10%. Neither the TPR nor the GBR agreements specify a process whereby the charge corridors might be expanded beyond 10%. Under this policy, underages below 10% in particular will not be added back to hospitals' approved revenues for the following year.

These corridors serve several purposes. They limit the ability of hospitals to cross subsidize or cost shift through undercharging in one center in order to overcharge in another center. Additionally, if a hospital's volume falls by more than 10%, this provision limits the ability of the hospital to charge up to its approved global revenue. A 10% decline in overall volume is substantial. The HSCRC staff believes that this mechanism will help ensure that the money follows the patient and that a hospital experiencing a substantial volume decrease will not be able to retain the revenue associated with that lost volume by increasing their unit rates without demonstrating the source of reductions. Rather volume shifted to other hospitals or to unregulated settings will result in an appropriate reduction in the hospital's global budget. Several purchasers have expressed concern about increasing unit rates when volumes are reduced. Consumer representatives also have agreed that this and other contract mechanisms are vital to helping protect consumers and ensure the patient-centeredness of the new All-Payer Model.

It must be noted though, that some hospitals and payer organizations have raised the concern that these charge corridors could undermine the efforts of hospitals to reduce potentially avoidable utilization by restricting their ability to keep and reinvest savings. Hospitals must make substantial investments in medical interventions, quality improvement, community based and primary care interventions, funding alignment models, internal care coordination and care coordination with other providers such as assisted living and skilled nursing facilities in order to improve population health and

achieve the desired results of the All-Payer Model. After making these considerable investments, hospitals are concerned that they may not be permitted to charge the full-approved global budget necessary to sustain these investments. Additionally, payers are concerned that hospitals will not continue efforts to reduce potentially avoidable utilization once the maximum volume reduction of 10% is reached within the charge corridor.

The HSCRC staff wants to address the concerns raised on both a short term and a longer-term basis. For now, HSCRC staff has identified factors that should be taken into consideration before a hospital will be granted permission to exceed the 10% charge corridor. At this time, we are not seeking to address undercharges that are beyond the 10% corridor. Although this could occur, it is a situation that would need to be addressed based on the surrounding facts and circumstances, because it would not result from successful application of the new All-Payer Model. Finally, charge variances that result from volume changes related to market share shifts or shifts to unregulated sites of care that fall within the 10% corridor will also be considered in the evaluation of market share adjustments and administration of the global budget agreements.

Considerations for 10% Charge Corridor Relief

If a hospital requests permission from the HSCRC to exceed the 10% charge corridor this request must appeal for relief needed in all rate centers. It is not the intent of the staff to allow concentration of rate adjustments resulting from volume declines in one or only a portion of centers or to allow cross-subsidization across centers. As outlined in the global agreements, staff expects these "balancing" rate adjustments to be spread across all centers evenly. The main purpose of granting relief is to provide stability and investment resources to hospitals and allow them the needed flexibility to adjust for significant volume declines as a result of reducing potentially avoidable utilization. There will be circumstances where HSCRC staff will not grant corridor relief. For example, it is possible that the volume declines may have resulted from market share changes, shifts to unregulated settings, temporary closures of services, or other actions which would not warrant an expansion of the corridors. Additionally, there may be some level of rate increase that would warrant an efficiency or shared savings adjustment due to the relative per capita or per episode efficiency of the hospital. In the near term, the HSCRC staff will need to focus on identifying and understanding the source of volume reductions and in turn, granting relief from the corridors when the volume reductions are consistent with the goals of the new Model.

Market Share Decline:

If a volume decrease is due to a decline in market share, 10% charge corridor relief should not be granted. Rather, through the market share policy, the variable portion of revenue associated with that market share decline should be removed from the global budget of the hospital experiencing the market share decline and added into the global budget of the hospital or hospitals that have realized a corresponding market share increase.

Shifts:

Under the TPR and GBR agreements, hospitals are required to notify the HSCRC of shifts of services to unregulated settings. If loss in volume is due to shifts to unregulated settings, 10% charge corridor relief should not be granted. The global budget of the hospital should be decreased at a level designed to ensure a net savings to the system and to Medicare.

Transfers:

If loss in volume is due to an increase in a hospital's transfer rate, 10% charge corridor relief should not be granted. Rather the variable revenue associated with those transferred patients should be remove from the global budget of the transferring hospital and added into the global budget of the receiving hospital or hospitals through the transfer policy.

Service Closures:

Under the TPR and GBR agreements, hospitals are required to notify the HSCRC of a service closure. Loss of volume due to service closures should not result in 10% charge corridor relief and should result in a reduction of the global budget.

Risk Avoidance:

HSCRC staff should monitor any changes in severity level of the requesting hospital to ensure that the requesting hospital is not experiencing a volume decline due to systematic avoidance of high-risk cases. HSCRC will focus on case mix and severity changes of the requesting hospital to evaluate the potential avoidance of providing necessary care.

Efficiency Outliers:

The HSCRC does not yet have efficiency measures in place for hospitals on global budgets. Ultimately, the HSCRC's goal will be to evaluate the total cost of care per capita and per episode. These measures are not available to guide the process in FY 2015. The staff does have some charge per case tools that have been used in the past. HSCRC staff will employ these tools and may choose to limit corridor relief when extreme outliers in existing charge per case measures or in rate comparisons are seen. Extremely inefficient outliers may not be granted permission to exceed the 10%.

Cost Containment and Investment Plans:

Loss in volume should result in reduced hospital costs. HSCRC staff will need to evaluate measures such as supply cost per adjusted discharge and labor cost per adjusted discharge

to ensure that the requesting hospital is taking the necessary steps to reduce costs when volumes are decreased

Review

To request relief, a hospital will need to submit the following information to staff:

1. A comparison of its base period volumes to the current volumes for each rate center, separated between inpatient and outpatient volumes.
    a. An explanation for any decrease in outpatient volumes will be necessary to ensure that shifts to unregulated settings or other hospitals have been accounted for.
    b. Staff will work with the hospital to gain information on the detected reductions. The hospital will need to update its annual attestation statement regarding known shifts of services.
2. A market share analysis should be completed.
    a. Staff has been working on several formats for this evaluation to evaluate volume changes by service line and to separately account for potentially avoidable utilization. Staff will work with the hospital to evaluate changes in market share. This should include an evaluation of transfers, temporary closures, or service discontinuation.
3. A comparison of case mix and severity levels between the base and current periods should be conducted.
    a. Any reductions in severity levels treated should be adequately explained.
4. The hospital should explain the actions it has taken and interventions implemented that have resulted in volume reductions.
    a. The hospital should show a reduction in PAU
    b. The hospital should describe the level of cost containment it has achieved.
5. The staff and hospital should review available information regarding efficiency, although as previously noted that the staff has not yet developed any per capita tools.

This process will become more automated over the course of the year as staff completes development of new tools and monitoring reports. The HSCRC recognizes though that the corridor relief review process will take time for both the hospital staff and HSCRC staff to conduct the review. HSCRC staff may grant temporary corridor relief for a limited time period during the review process.

Base Volumes

In order to maintain the placement of the corridors, the base period volumes (FY 2013) will need to be fixed and adjusted only for allowed volume changes due to granted population adjustments, market share shifts, or reductions based on revenue constraints made in the base period.

There is a potential issue with rate realignment that could result from the maintenance of base period. For FY 2015, this is not a concern because the base year and the annual filing year used for rate realignment are both FY 2013. For FY 2016, the HSCRC staff is aware that it will need to evaluate how to update volumes to FY 2014 to bring the rate realignment into synchronization. There are several options, and these can be addressed once staff evaluates the magnitude of volume differences between FY 2013 and FY 2014.