Review of Global Budget Contracts

Introduction

Under the new All-Payer Model in Maryland, hospitals have chosen to have their revenues regulated under global models as the system moves from a system focused on cost-per-case to a system that has a three part aim of promoting better care, better health, and lower cost. In contrast to the previous Medicare waiver that focused on controlling increases in Medicare inpatient payments per case, the new All-Payer Model focuses on controlling increases in total hospital revenue per capita.

Central to the All-Payer Model are global revenue models that encourage hospitals to focus on population health and care improvement by prospectively establishing an annual revenue budget for each hospital. There are two global models being used: The Total Patient Revenue (TPR) model was expanded in 2008 and now includes 10 hospitals in more rural areas of the State. In 2013, the Global Budget Revenue (GBR) model, which was based on the TPR methodology, was introduced to all other hospitals in the State, including those in urban and suburban areas.

Under GBR and TPR, each hospital's total annual revenue is known at the beginning of the fiscal year. Total annual revenue is determined from a historical base period that is adjusted to account several factors.

In order to evaluate the potential for immediate changes that are needed for the GBR and TPR agreements as well as addressing any policy issues raised during the implementation of these agreements, HSCRC staff reviewed both GBR and TPR agreement templates and provided a summary of the provisions for discussion and review with a subgroup that broadly represented stakeholders from all groups. This draft report contains recommendations arising from the review of the agreement templates that require near term changes as well as recommendations for consideration when redrafting the contract in its entirety.

Overview of Demographic Adjustment Calculation

Updates--Many of the agreement provisions of both GBR and TPR are identical or similar. This is expected because the GBR agreement was modeled after the TPR agreement, with some modifications to reflect the difference in nature of TPR and GBR hospitals. There was general consensus that it would be appropriate to move to a single agreement when the agreement is

redrafted that would cover both TPR and GBR arrangements, recognizing that there may be differences in the terms of the agreements due to the nature of the hospitals and the situations resulting from the different lengths of time hospitals have been under the model. In particular, the GBR agreement contains a number of clauses aimed at consumer protection. It is important that these protections be available in all circumstances and that the intent be explicitly stated. The aim would be to have a new standard agreement in place for FY 2016, while addressing any immediate requirements with an addenda to existing agreements. This will give adequate time to update the document, while addressing the more immediate concerns.

Reporting templates--The GBR agreement provides for monthly reports on compliance and other aspects of the model. Additionally, the GBR agreement calls for a report on investments and infrastructure for implementing the agreement (e.g. case managers, care coordinators, etc.). HSCRC staff has asked for assistance from DHMH in developing the reporting requirements for infrastructure. HSCRC staff will ask for volunteers and convene each subgroup with a goal of completion over the next two to three months.

Underage and overages--The GBR agreement addresses underages and overages relative to the total global budgets. It includes a provision that provides for a penalty of 40% when underages or overages exceed .5%. Commenters felt that this corridor may be too tight and that it did not fully address the need to limit carry forwards of undercharges from year to year. HSCRC staff notes the need for enhanced compliance under the new All-Payer Model. Nevertheless, the following table is proposed to replace the .5% corridor in the GBR agreement, and also be provided as an addendum to TPR agreements.

Proposed Corridors Relative to Overages	
Overages	
0 to .5% above total approved revenue budget	No penalty
.5% to 1% above total approved revenue budget	40% penalty
1% and more above total approved revenue budget	50% penalty
Proposed Corridors Relative to Underages	
Underages	
0 to .5% below total approved revenue budget	No penalty
.5% to 1% above total approved revenue budget	20% penalty applied to reduce carryover
1% to 2% above total approved revenue budget	50% penalty applied to reduce carryover
Above 2%	No carryover

Unit rate charge corridors--Both TPR and GBR agreements have charge corridors to allow hospitals to increase or decrease charges to stay in compliance with the overall revenue budget target. If rates exceed or are lower than 5% of unit rates, then the hospital must seek permission to expand the charge corridor to 10%. The agreement does not address a process to provide corridors above 10%. Underages below 10% are not added back to hospitals' approved revenues. The HSCRC staff intended to address several issues of concern with this policy.

Policy Intent	Commentary
HSCRC staff does not want to allow cross subsidization or shifting through undercharging in one center that is made up by overcharging in another center.	The limits provide some assurance that this will not occur beyond the corridors. Contracts state that the policy is to spread overages and underages ratably, and staff will be on the look out for other patterns.
HSCRC staff wants to review volume decreases, to ensure that they are not the result of a market share shift or failure to provide needed services. • If hospitals need to increase rates beyond the corridor of either 5% or 10%, this means that volumes have fallen overall by more than 5% or 10%.	There is a concern that the agreement does not specify how the intended policy will be addressed in evaluating requests for corridor relief. There is also a concern that there should be corridor relief beyond 10% to allow hospitals to continue to address reductions in avoidable utilization. Recommendation: HSCRC staff should draft a policy that addresses these concerns and outlines how it will review requests. In general, the HSCRC staff will want the hospital to demonstrate that its market share has not decreased, services have not been shifted outside of the hospital, and that the hospital has not stopped providing needed services or serving severely ill patients. If avoidable volumes have fallen below 10%, HSCRC staff will want to ensure that variable operating costs have been reduced commensurate with volume reductions over an appropriate period of time. Furthermore, the hospital should present a plan relative to volume reductions beyond 10%, including the funds that are needed for investments in population health, care improvement interventions, and physician alignment activities. Additionally, the plan should address the amount of savings that will be shared with the purchasers and payers.
HSCRC staff indicated that the corridor policy requires that the base period volumes be maintained in place to avoid undermining the intent. TPR hospitals had their volumes updated annually and this has undermined the intent for these hospitals. Moving forward, the intent will be retained.	There was a concern raised that rate realignment cannot occur effectively if volumes are not updated. HSCRC staff agrees with the importance of rate realignment. The policy can be maintained by updating the volumes but maintaining the corridors through the rates assigned. For example, if the hospitals volumes have dropped overall by 3%, then the rates assigned should produce total revenues that are 3% below the overall cap. This will allow rate realignment to occur while maintaining the intent of the agreement. If the hospital receives a demographic adjustment, this can be reflected by increasing the volumes used in calculating the allowed revenue and treated as a volume

	increase.

These are the main clauses that require immediate attention. The attachment summarizes the key terms and discussions relative to the proposed amendment of the contract for the 2016 renewal year.

December 31 targets--While the agreements are for fiscal years, the hospitals need to maintain compliance with targets that are for calendar years, due to the nature of both the All-Payer Model and Medicare savings requirements which are calculated on a calendar year basis. A contract addenda should be provided with the July 1, 2014 rate orders that specifies the December 31 target that should not be exceeded.