REPORT

ON

EXISTING GLOBAL BUDGET CONTRACTS

AND CHANGES FOR RATE

YEAR 2015 AND BEYOND

Health Services Cost Review Commission
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This report has been prepared for presentation to the Commission at the July 2014 Public Commission Meeting. No action is required.

A. Introduction

During the last six months, all hospitals in Maryland have chosen to have their revenues regulated in a manner consistent with the new All Payer Model. The All Payer Model reflects the transition from a rate setting system that has been focused on cost-per-case to one that has a three part aim of promoting better care, better health, and lower cost. In contrast to the previous Medicare waiver, which focused on controlling increases in Medicare inpatient payments per case, the new All-Payer Model is focused on controlling increases in total hospital revenue per capita.

At the core of 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. The HSCRC is currently using two global models: the Total Patient Revenue (TPR) model, which has existed for more than thirty years, and which now covers ten (10) hospitals located in relatively rural areas of the State; and the Global Budget Revenue (GBR) model, which was introduced in 2013, based on the pre-existing TPR methodology, and which is available to all hospitals in the State, including those in urban and suburban areas.

Under both the GBR and TPR models, each hospital's total annual approved revenue is established by formal agreement at the beginning of the fiscal year. Total annual revenue is derived from a historical base period level of revenue that is adjusted to the rate year for inflation, retroactive (plus or minus) changes (for compliance, etc.), volume levels, and other factors in accordance with HSCRC-approved policies.

The HSCRC staff believes it is timely and appropriate to evaluate the need for any immediate changes in the GBR and TPR agreements and to address policy issues that arose during or after the implementation process. Accordingly, the HSCRC staff developed a summary of the key provisions of the GBR and TPR contract "templates" and provided that summary to a subgroup of the Payment Models Work Group for review and discussion. The reviewers were asked to provide their recommended changes. The subgroup that engaged in the review was representative of stakeholders from consumers, payers, employers, and providers. The results of the detailed review by the subgroup were shared with the Payment Models Work Group. Additional input from the Payment Models Work Group was also considered by the HSCRC staff.

This Report summarizes the recommendations that arose from the review of the TPR and GBR templates. These recommendations will require both short-term and long-term consideration by the staff and the Commissioners before any changes are implemented.

A. Overview of Global Budgets

The TPR and GBR agreements provide for the operation of global revenue budgets within the following framework:

- Total annual revenue is determined from a historical base period that is adjusted to account for several factors.
- A fixed revenue base is set for a 12 month period with annual adjustments.
- Hospitals retain revenue related to reductions in potentially avoidable utilization (PAU)
- Hospitals can invest savings in care improvement, use the revenue capacity to provide enhanced services, or make other use of the savings.
- Annual updates are provided for inflation, based on Commission approved levels.
- Annual quality adjustments are provided based on Commission approved policies.
- An allowance is provided for demographic changes based on the agreements.
- The revenues are subject to adjustment for efficiency and other adjustments determined by HSCRC policy. Revenues are subject to adjustments to maintain compliance with the All-Payer Model.
- The agreements provide for potential adjustments for shifts in service loads between regulated hospitals (referred to as market share adjustments) or to unregulated settings.
- Other annual adjustments include those for payer mix differential, changes in assessments, price variances, overages and underages from the approved global budget, and uncompensated care.

Once the overall revenues are approved, unit rates are calculated for each hospital by HSCRC staff based on historical volumes and existing rate setting principles. The Commission issues hospital-specific rate orders that contain unit rates and overall allowed revenues.

Hospitals are permitted to increase or decrease their approved unit rates in order to generate their overall approved revenue. If volumes decrease, the hospitals are permitted to raise their unit rates to generate the approved level of revenue. Conversely, if volumes increase, the hospitals are expected to decrease their unit rates so that they will remain in compliance with their overall approved revenue budgets.

B. Review of Global Agreements and Recommendations

1. *Updates*

Many of the specific provisions in the GBR and TPR agreements are identical or similar to each other. This similarity is not surprising because the GBR agreement was modeled on the pre-existing TPR agreement. The most significant differences between the GBR agreements and the previous TPR agreements consist of modifications that were needed to conform the new TPR and GBR agreements to the new All-Payer Model and to add some consumer protections (e.g., assurances that needed services will be provided in a high quality manner, etc.). The TPR agreements do not include some of the specific clauses that have been included in the GBR

agreements to address these issues, but they do include general clauses that the HSCRC staff believes are sufficiently encompassing.

The review group ("Commenters") agreed that it would be appropriate to move to a single agreement, which would cover both TPR and GBR arrangements, when the current GBR agreement template is redrafted. The reviewers acknowledged that some differences in the terms of the agreements will be appropriate on a hospital-specific basis due to the location of the hospitals, the varying lengths of time that the hospitals have operated under the models, and other factors. The reviewers recommended that the HSCRC staff should develop a new standard template agreement for FY 2016 and address any immediate changes that are needed before FY 2016 through addenda to existing agreements. This schedule would give the HSCRC staff adequate time to update the existing TPR and GBR agreements into a new model template and would allow the staff to address any immediate concerns through adjustments to particular existing agreements.

2. Reporting Templates

The GBR agreement requires the hospitals to submit monthly reports on compliance and other aspects of the operations and impact of the GBR model. The GBR agreement also requires the hospitals to report on their investments in infrastructure support (e.g., case managers, care coordinators, etc.) that are designed to promote achievement of the various goals of the All Payer Model. The HSCRC staff will convene subgroups of the Payment Models Work Group with a goal of providing reporting templates by early fall.

3. Underage and Overages

As described above, each of the GBR and TPR hospitals is provided with an aggregate revenue budget for the upcoming rate year. A hospital is permitted to adjust its unit rates, within defined maximum corridors, to generate the approved aggregate revenue. If a hospital charges less than the aggregate approved revenue, this difference is referred to as an underage. Conversely, charges above the approved aggregate revenue are referred to as an overage. The GBR and TPR agreements address underages and overages, relative to the global budgets, by providing that underages (or overages) will be added to (or subtracted) from the total approved budget for the succeeding rate year as one-time adjustments.

The GBR agreement provides for a penalty of 40% when underages or overages exceed 0.5%. The HSCRC staff established this strict compliance policy because of the pressing need for enhanced compliance under the new All-Payer Model. Additionally, the HSCRC staff does not want to carry forward underages beyond a reasonable level to the budget of the following year, because that practice could yield unexpected and detrimental fluctuations in revenue budgets. It might also result in overall revenue budgets and unit charges that are unreasonable, if the underages resulted from the inability of particular hospitals to charge up to the level of their revenue budget because of large overall volume reductions. Nevertheless, some reviewers felt that a corridor of 0.5% may be too tight.

The TPR agreement, which was crafted before the new All Payer Model was conceptualized or implemented, does not include penalties for overages or limits on the carryover of underages.

The HSCRC staff is planning to change the corridors for GBR hospitals and to introduce the same corridors for TPR hospitals, as shown in Table 1. These corridors would be implemented through addenda to the existing TPR and GBR agreements during the rate update process for FY 2015.

Table 1

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

Intentional overcharges are not permitted under the TPR/GBR agreements. If HSCRC staff observes a pattern of overcharges by some hospitals, it will reduce the overcharge corridor and increase the penalties on a hospital-specific basis.

4. Unit Rate Charge Corridors

As discussed above, both the TPR and GBR agreements allow hospitals to increase or decrease their approved unit rates to generate the overall approved global revenue for the hospital. However, the HSCRC's rate system includes a corridor that limits increases or decreases. If rate changes exceed or are lower than 5% of approved unit rates, then the hospital must seek permission to expand the charge corridor to 10%. Neither the TPR nor the GBR agreements specify a process whereby the corridors might be expanded beyond 10%. In particular, underages below 10% are not added back to hospitals' approved revenues. The HSCRC staff intends to address several issues of concern that have been raised concerning this policy based on initial input from the Work Group. A subgroup of the Payment Models Workgroup is being formed with the intent to address these issues by early fall.

Table 2

Policy Intent of Corridors	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 assurance that this will not occur beyond the corridors.
If volume decreases would require rate increases beyond 10% to reach the approved revenue budget, the HSCRC staff wants to review the volume reductions to ensure that they are not the result of a shift of services to another regulated hospital, a shift to a non-regulated setting, or a failure to provide needed services.	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 reduce avoidable utilization. Recommendation: HSCRC staff should form a subgroup to develop clear approaches to management of the agreement that will promote achievement of the goals of the global budget (e.g., promoting clinical improvement and reducing potentially avoidable utilization), while also addressing concerns relative to shifts or failure to provide services. This review should be done promptly in order to reduce uncertainty about the operation of global budgets and the investments that hospitals will need to make to reduce avoidable utilization and improve care and clinical management.
In order for the corridors to function, HSCRC staff indicated that the base period volumes would be maintained in place unless the revenue was rebased. This maintains consistency between the revenue budget and the initial volumes that established the budget.	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. HSCRC staff will work with the subgroup referred to above to address this issue and make recommendations for consideration by the Payment Models Work Group.

5. December 31 Revenue Targets

While the TPR and GBR agreements are for fiscal years, the hospitals need to maintain compliance with calendar year targets, since both the All-Payer Model revenue limits and Medicare savings requirements are measured on a calendar year basis. The HSCRC Staff will provide a contract addendum for FY 2015 and beyond that will specify December 31 revenue targets that should not be exceeded on a hospital-specific basis.

C. Demographic Adjustment

As indicated above, the TPR and GBR agreements adjust approved hospital revenue levels to reflect demographic changes (i.e., increases/decreases in population and changes in the age/sex mix). In the past, the HSCRC staff developed a revenue adjustment based on county level

population estimates, which was used for the TPR hospitals. For GBR hospitals, most of which are located in urban or suburban areas, the HSCRC staff developed a newer, more precise demographic adjustment using a "virtual patient service area" (VPSA) for each hospital. This VPSA-based method adjusts the revenue budgets to reflect hospital service volume changes that are expected due to changes in the demographics of each hospital's VPSA. The adjustments do not permit increases in hospital service volumes that are due to potentially avoidable utilization (PAU).

The new, VPSA-based volume adjustment approach also includes a per capita efficiency factor that is designed to bring the overall demographic adjustment under the GBR models within the level of volume growth that is permitted under the new All-Payer Model (which is based solely on population growth).

The reviewers recommended that the HSCRC should use an expanded number of age cohorts in the volume adjustment. The HSCRC staff has accepted this recommendation and applied it in the updated calculations. The reviewers were also concerned about the initial (i.e., FY 2014) demographic calculation because it used statewide PAU percentages in reducing the age-adjusted weights, whereas the levels of PAU vary across the State. The staff has responded by removing the PAU percentages from the weights and applying the overall PAU adjustment on a hospital-specific basis. A more detailed description of the updated demographic adjustment can be found at: http://www.hscrc.state.md.us/pdr_clarifications.cfm .

D. Summary

The TPR and GBR global budget agreements are already similar to each other and should be consolidated when new templates are developed. Appropriate differences associated with individual hospitals should be retained. The target date for completion of a new template covering both TPR and GBR hospitals is FY 2016.

The demographic adjustment used for the GBR agreement for FY 2014 has been updated for FY 2015.

The HSCRC staff needs to develop several TPR/GBR reporting templates and will proceed to do so with input from the work group.

The following TPR/GBR contract provisions require immediate action as described:

- Corridors: The HSCRC staff has developed a new provision regarding overall corridors for the agreements and intends to implement this provision through an addendum to the existing agreements.
- December Revenue Targets: The HSCRC staff will provide each hospital with a December 31 revenue target. These targets will be implemented through an agreement addendum.

- Implementation of Corridor Limits: The HSCRC staff needs to remove uncertainty regarding the way in which the corridors will be implemented. This activity should be undertaken and completed by the fall. The staff intends to work with a subgroup of the Payment Models Work Group to review the operation of corridors. Staff will provide the Commission with an update on this activity in the fall.