Final Recommendations on the Update Factors for FY 2018

June 14, 2017

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This document reflects the Final Recommendation on the Update Factors for FY 2018 as ultimately approved by the Commission on June 14, 2017.

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LIST OF ABBREVIATIONS

ACA	Affordable Care Act
ACO	Accountable Care Organization
CAGR	Compound Annual Growth Rate
CMMI	Center for Medicare & Medicaid Innovation
CMS	Centers for Medicare & Medicaid Services
CY	Calendar year
DBM	Department of Budget Management
DSH	Disproportionate Share Hospital
FFS	Fee-for-service
FFY	Federal fiscal year
FY	Fiscal year
GBR	Global budget revenue
HSCRC	Health Services Cost Review Commission
MACRA	Medicare Access and CHIP Reauthorization Act
MHA	The Maryland Hospital Association
PAU	Potentially avoidable utilization
RY	Rate year
UCC	Uncompensated care

INTRODUCTION AND BACKGROUND

The Maryland Health Services Cost Review Commission (HSCRC or Commission) has been setting hospital payment rates for all payers since 1977. As part of this process, the HSCRC updates hospitals' rates and approved revenues on July 1 of each year to account for factors such as inflation, policy related adjustments, other adjustments related to performance, and settlements from the prior year.

On January 1, 2014, the Centers for Medicare & Medicaid Services (CMS) approved the implementation of a new All-Payer Model in Maryland. The All-Payer Model aims to promote better care, better health, and lower costs for all Maryland patients. In contrast to Maryland's previous Medicare waiver that focused on controlling increases in Medicare inpatient payments per case, the All-Payer Model (Model) focuses on controlling increases in total hospital revenue per capita. The Model established a cumulative annual limit on per capita growth of 3.58 percent and a Medicare savings target of $330 million over the initial five-year period of the Model.

In order to meet the requirements of the All-Payer Model and assure that the annual update will not result in a revenue increase beyond the 3.58 percent limit, the update process needs to account for all sources of hospital revenue that will contribute to the growth of total Maryland hospital revenues for Maryland residents. In addition, the HSCRC needs to consider the effects of the update on the Model's $330 million Medicare savings requirement and the total hospital revenue that is set at risk for quality-based programs. While rates and global budgets are approved on a fiscal year basis, the All-Payer Model revenue limits and Medicare savings are determined on a calendar year basis. Therefore, the HSCRC must account for both calendar year and fiscal year revenues in establishing the updates for the fiscal year.

It is important to note that the proposed update incorporates both price and volume adjustments for revenues under global budgets. Thus, the proposed update should not be compared to a rate update that does not control for volume changes. It is also important to view the revenue updates in the framework of gross and net revenue. Specially, during the past three years, the expansion of Medicaid and other Affordable Care Act (ACA) enrollment has reduced uncompensated care (UCC), resulting in the State reducing several revenue assessments. The rate reductions for UCC and associated assessment reductions implemented by HSCRC decrease gross revenues, but they do not decrease net revenues. Therefore, the net revenue increases are higher than gross revenue increases during these periods.

For rate year (RY) 2017, there were three categories of hospital revenue. One category included out-of-state revenues for several Johns Hopkins Health System hospitals. However, this revenue was brought under the global budget during RY 2017. As a result, there are only two remaining categories of hospital revenue under the All-Payer Model:

1. Hospitals under Global Budget Revenues, which are under the HSCRC's full rate-setting authority.

2. Hospital revenues for which the HSCRC sets the rates paid by non-governmental payers and purchasers, but where CMS has not waived Medicare's rate-setting authority to Maryland and thus Medicare does not pay on the basis of those rates. This includes psychiatric hospitals and Mount Washington Pediatric Hospital.

The purpose of this report is to present analyses and make recommendations for the update factors for RY 2018 for global revenues and non-global revenues.

ASSESSMENT

Overview of Final Update Factors Recommendations

Since the initiation of the All Payer Model effective January 1, 2014, Maryland hospitals in the aggregate have been provided revenue budgets that allow for investments in care coordination and other infrastructure to implement care improvement and population health initiatives. During the first two years of the Model, hospitals also experienced increased profitability from regulated revenues. That improvement in financial condition can be credited, in large measure, to the successes of hospitals in rapid adoption of global budget models, adoption of interventions that have moderated or decreased potentially avoidable utilization, implementation of cost controls, and increases in revenues provided by the HSCRC for care coordination and infrastructure. Additionally, actual inflation estimates turned out to be lower than the amount provided for inflation in rate updates for the initial two years of the Model. This higher inflation in rates allowed for additional investments in care coordination and population health.

In RY 2017, there were large declines in the federal Medicare update factor for the federal fiscal year (FFY) 2017 under the ACA and limited Maryland hospital savings in calendar year (CY) 2015 relative to the national Medicare growth. As a result, the HSCRC approved an update that lowered approved revenues for PAU by an additional 0.45 percent. As a result of this reduction, as well as higher inflation and other factors, hospital margins declined. Medicare hospital savings have again increased in CY 2016.

As described in detail below, for RY 2018, HSCRC staff is proposing a preliminary update of 2.77 percent per capita for global revenues and a preliminary update of 2.28 percent for non-global revenues.

Calculation of the Inflation/Trend Adjustment for Global and Non-Global Revenues

The calculation of the inflation/trend adjustment Global Revenues and Non-Global Revenues, including psychiatric hospitals and Mt. Washington Pediatrics, starts by using the gross blended statistic of 2.68 percent growth, which was derived from combining 91.2 percent of Global Insight's First Quarter 2017 market basket growth of 2.80 percent with 8.80 percent of the capital growth estimate of 1.40 percent, which calculates to 2.68 percent. The proposed inflation/trend adjustment would be as follows:

Table 1. RY 2018 Proposed Inflation/Trend Adjustment

	Global Revenues	Psych & Mt. Washington
Proposed Base Update (Gross Inflation)	2.68%	2.68%
Productivity Adjustment		-0.40%
Proposed Update	2.68%	2.28%

For psychiatric hospitals and Mt. Washington Pediatric Hospital, staff is proposing to use a productivity adjustment of 0.40 percent. This results in a proposed update of 2.28 percent. Additionally, these hospitals get a volume adjustment rather than a population adjustment. HSCRC staff is currently working on implementing quality measures for future rate years.

Summary of Other Policies Impacting RY 2018 Revenues

The inflation/trend adjustment is just one component of the adjustments to hospital global budgets for RY 2018. Therefore, in considering the system-wide update for the hospital global budgets under the All-Payer Model, HSCRC staff sought to achieve balance among the following conditions: 1) meeting the requirements of the All-Payer Model agreement; 2) providing hospitals with the necessary resources to keep pace with changes in inflation and demographic changes; 3) ensuring that hospitals have adequate resources to invest in the care coordination and population health strategies necessary for long-term success under the All-Payer Model; and 4) incorporating quality performance programs.

Table 2 summarizes the net impact of the HSCRC staff's current proposals for inflation, volume, PAU savings, UCC, and other adjustments on global revenues. The proposed adjustments provide for an estimated net revenue growth of 3.32 percent and per capita growth of 2.95 percent for RY 2018, before accounting for reductions in UCC and assessments. After accounting for those factors, the revenue growth is estimated at 3.14 percent with a corresponding per capita growth of 2.77 percent for RY 2018. Descriptions of each step and the associated policy considerations are explained in the text following the table:

Table 2. Net Impact of Adjustments on Hospital Global Revenues, RY 2018

Balanced Update Model for Discussion			
Components of Revenue Change Linked to Hospital Cost Drivers/Performance			
			Weighted Allowance
Adjustment for Inflation			2.40%
- Total Drug Cost Inflation for All Hospitals*			0.28%
Gross Inflation Allowance	A		2.68%
Care Coordination			
-Rising Risk With Community Based Providers			
-Complex Patients With Regional Partnerships & Community Partners			
-Long Term Care & Post Acute			
	B		
Adjustment for volume	C		0.56%
-Demographic Adjustment (0.36%)			
-Transfers			
-Categoricals			
- Drug Population/Utilization (.2%**)			
Other adjustments (positive and negative)			
- Set Aside for Unknown Adjustments	D		0.20%
- Medicare Performance Adjustment (Future Use)	E		0.00%
Net Other Adjustments	F =	Sum of D thru E	0.20%
- Reversal of one-time adjustments for drugs	G		-0.10%
-Reverse prior year's PAU savings reduction	H		1.25%
-PAU Savings	I		-1.45%
-Reversal of prior year quality incentives -QBR, MHAC, Readmissions	J		-0.12%
-Positive incentives & Negative scaling adjustments	K		0.30%
Net Quality and PAU Savings	L =	Sum of G thru K	-0.12%
Net increase attributable to hospitals	M =	Sum of A + B + C + F + L	3.32%
Per Capita	N =	(1+M)/(1+0.36%)	2.95%
Components of Revenue Offsets with Neutral Impact on Hospital Finanical Statements			
-Uncompensated care reduction, net of differential	O		-0.18%
-Deficit Assessment	P		0.00%
Net decreases	Q =	O + P	-0.18%
Revenue growth, net of offsets	R =	M + Q	3.14%
Per capita revenue growth	S =	(1+R)/(1+0.36%)	2.77%

* Provided Based on proportion of drug cost to total cost (drug index 5.2% X 5.4% national weight)

**Prospective adjustment 0.10 percentfor new outpatient infusion and chemotherapy drugs (50% of estimated input in rates the beginning of FY)
The second 0.10 percent will be earmarked for new outpatient infusion and chemotherapy drugs (50% of actual input in rates mid-year)

For RY 2017, the HSCRC split the approved revenue for the year into two targets, a mid-year target and a year-end target. Through this process, the HSCRC deferred a portion of the update from CY 2016 into CY 2017. This deferral was meant to address a particularly low federal Medicare update for FFY 2017, and also better matched the historic volume patterns incurred by hospitals, with higher volumes through the winter months of January through March. Because this revenue split matched historical volumes better, the HSCRC staff plans to continue this split. The staff will apply 49.73 percent of the Total Approved Revenue to determine the mid-year target and the remainder of revenue will be applied to the year-end target. Of note, there are a few hospitals that do not follow this seasonal pattern, particularly Atlantic General Hospital. Thus, HSCRC staff will adjust the revenue split to accommodate their normal seasonality.

Also, in the first half of RY 2017, hospitals undercharged their global budgets by approximately 1.0 percent. To recover this undercharge, hospitals will need to increase revenues in the second half of the RY 2017. This will contribute to an increase in the total cost of care for CY 2017. HSCRC has made CMMI aware of this undercharge, and its implications for CY 2017 data.

Central Components of Revenue Change Linked to Hospital Cost Drivers/Performance

HSCRC staff accounted for a number of factors that are central provisions to the update process and are linked to hospital costs and performance. These include:

- **Adjustments for Volume**: Staff proposes a 0.36 percent adjustment that is equal to the Maryland Department of Planning's estimate of population growth for CY 2017[1]. In the previous year, staff used an estimate based on five-year population growth projections. For the last two years (i.e., RYs 2016 and 2017), the actual growth estimate has been lower than the forecast. Hospital-specific adjustments will vary based on changes in the demographics of each hospital's service area. In the past, a portion of the adjustment was set aside to account for growth in highly specialized services. For RY 2018, the staff proposes to provide the full value of the 0.36 percent growth for the demographic adjustment to hospitals.
- **Rising Cost of New Drugs**: The rising cost of drugs, particularly of new physician-administered drugs in the outpatient setting, continues to be a growing concern among hospitals, payers, and consumers. Not all hospitals provide these services, and some hospitals have a much larger proportion of costs devoted to these services. To address this situation, staff recommends earmarking 0.28 percent of the inflation allowance to fund increases in the cost of drugs and to provide this allowance to the portion of total hospital costs that were comprised of drug costs in FY 2016. Staff also proposes to provide a prospective volume adjustment of 0.10 percent to fund a portion of the rising cost of new outpatient physician-administered drugs, which will be provided on a hospital-specific basis. Each hospital with regulated oncology drugs reported drug costs for outpatient infusion, chemotherapy, and biological drugs that accounted for at least

[1] See http://planning.maryland.gov/msdc/.

80 percent of drugs billed for RY 2016. Staff will spread the 0.10 percent adjustment among those hospitals based on their 2016 actual costs that were submitted for RY 2016. In addition, staff will collect similar data for RY 2017, and will provide an update of an estimated 0.10 percent effective with the mid-year 2018 update. In doing so, staff will provide a 0.20 percent volume adjustment for drugs, together with a 0.28 percent inflation allowance for drugs. During RY 2017, staff provided a retrospective and prospective volume adjustment for drugs, each of approximately 0.10 percent. The one-time adjustment portion will be reversed. The HSCRC staff expects to continue to refine the policies as it receives additional cost and use information.

- **Set-Aside for Unforeseen Adjustments**: Staff recommends a 0.20 percent set-aside to fund unforeseen adjustments during the year. This amount was reduced from 0.50 percent in RY 2017 to provide funding for a drug adjustment in RY 2018.
- **Reversal of the Prior Year's PAU Savings Reduction and Quality Incentives**: The total RY 2017 PAU savings and quality adjustments are restored to the base for RY 2018, with new adjustments to reflect the PAU savings reduction and quality incentives for RY 2018.
- **PAU Savings Reduction and Scaling Adjustments**: The RY 2018 PAU savings will be continued, and an additional 0.20 percent savings is targeted for RY 2018. Staff have provided preliminary estimates for both positive and negative quality incentive programs, which have been changed so that they are no longer revenue neutral. However, staff is still working on finalizing these figures.

Central Components of Revenue Offsets with Neutral Impact on Hospital Financial Statements

In addition to the central provisions that are linked to hospital costs and performance, HSCRC staff also considered revenue offsets with neutral impact on hospital financial statements. These include:

- **UCC Reductions**: The proposed UCC reduction for FY 2018 will be -0.18 percent. The amount in rates was 4.69 percent in RY 2017, and the proposed amount for RY 2018 is 4.51 percent.
- **Deficit Assessment**: The legislature did not reduce the deficit assessment for FY 2018. Therefore, this line item is set at 0 percent.

Additional Revenue Variables

In addition to these central provisions, there are additional variables that the HSCRC considers, as mentioned in Table 2. These additional variables include one-time adjustments, as well as revenue and rate compliance adjustments and price leveling of revenue adjustments to account for annualization of rate and revenue changes made in the prior year. Notable factors include the PAU savings adjustment and investments in care coordination, as described in additional detail below.

PAU Savings Adjustment

Maryland is now in its fourth performance year of the All-Payer Model. The Model is based on the expectation that an All-Payer approach and global or population-based budgets will result in more rapid changes in population health, care coordination, and other improvements, which in turn will result in reductions in PAUs. To that end, the Commission approved budgets that did not offset Medicare's ACA and productivity adjustments, and provided infrastructure investment funding to support care coordination and population health activities. For RYs 2015 and 2016, the HSCRC applied a PAU savings adjustment with an incremental revenue reduction averaging 0.20 percent to allocate and ensure savings for purchasers of care. In RY 2017, there was an incremental increase in the PAU adjustment of 0.45 percent. For RY 2018, staff is proposing an increase in the PAU saving adjustment of 0.20 percent, similar to RYs 2015 and 2016.

Investments in Care Coordination and Implementation of Care Interventions

Investments

The HSCRC provided funding for some initial investments in care coordination resources. Staff believes that several categories of investments for implementation are critical to the success of the Model. Multiple workgroups have identified the need to focus on high needs patients, complex patients, and patients with chronic conditions and other factors that place them at risk of requiring extensive resources. Of particular concern are Medicare patients, who have more extensive needs, but fewer system supports. Additionally, there are several major opportunities with post-acute and long-term care that are important to address. There is significant variation in post-acute care costs, and hospitals need to work with partners to address this variation. There are also potentially avoidable admissions and readmissions from post-acute and long-term care facilities. There are documented successes in reducing these avoidable admissions, both in Maryland and nationally. These improvements require partnerships and coordination among hospitals and long-term and post-acute care providers. As hospitals continue to implement these approaches in FY 2017, declines in utilization may free up resources to make additional investments (if there is not a corresponding increase in non-hospital costs). The HSCRC staff has completed an amendment to the All-Payer Model to provide data and additional flexibility in implementing care redesign together with physicians and community-based partners. Also, the State has proposed a Maryland Comprehensive Primary Care Model (MCPCM) to CMS, which it hopes to initiate in early 2018. The MCPCM will provide care management resources to participating primary care practices.

Implementation of the care redesign and population health improvement will require additional investments. It will be important to reinvest hospital resources and to identify aligned resources outside of hospitals to make these efforts successful.

Additional resources could be beneficial for organizations that are prepared to implement:

- Care management for complex patients, in collaboration with regional partnerships and community partners

- Care coordination and chronic care improvement focused on rising risk patients as well as population health improvement, in collaboration with community partners
- Effective approaches to address post-acute and long-term care opportunities
- Other care redesign programs that engage physicians and other non-hospital providers in efforts aligned with the All-Payer Model

Interventions

As part of the FY 2017 update, each hospital in the State agreed to focus on total cost of care for Medicare, implement increased interventions and care coordination for high needs and rising needs patients, and to work with physicians relative to Medicare Access & CHIP Reauthorization Act (MACRA) opportunities. As discussed in the following section entitled Medicare Financial Test, for CY 2016, the State was successful in limiting the growth in Medicare total cost of care relative to national growth. Hospitals have been working with CRISP to share information on care coordination activities for high needs patients, and this information is being reviewed in the aggregate each month. As mentioned, the State has worked with stakeholders to secure a Care Redesign Amendment to the All-Payer Model. The clearance process for the Amendment took longer than anticipated, and the Amendment was just signed with CMS at the end of April 2017. Hospitals have also been participating in Accountable Care Organizations (ACOs). Additional effort is still needed to implement increasing levels of interventions for high needs patients and to engage physicians and other providers in aligned efforts. HSCRC staff is considering the importance and implications of these efforts on the Model's ongoing success. Staff is interested in Commissioners' and stakeholders' views on how progress on these efforts should be taken into account for the upcoming rate year.

Consideration of All-Payer Model Agreement Requirements

As described above, the staff proposal increases the resources available to hospitals to account for rising inflation, population changes, and other factors, while providing adjustments for performance under quality programs. Additionally, based on the staff calculations to date, the proposed update falls within the financial parameters of the All-Payer Model agreement requirements. However, staff does not yet have the updated cost per beneficiary estimates for CY 2017, and thus these calculations are subject to change. The staff's considerations in regards to the All-Payer Model agreement requirements are described in detail below.

All-Payer Financial Test

The proposed balanced update keeps Maryland within the constraints of the Model's all-payer revenue test. Maryland's agreement with CMS limits the annual growth rate for all-payer per capita revenues for Maryland residents at 3.58 percent. Compliance with this test is measured by comparing the cumulative growth in revenues from the CY 2013 base period to a ceiling calculated assuming an annual per capita growth of 3.58 percent. To evaluate the impact of the recommended update factor on the State's compliance with the all-payer revenue test, staff

calculated the maximum cumulative growth that is allowable through the end of CY 2018. As shown in Table 3, cumulative growth of 19.23 percent is permitted through CY 2018.

Table 3. Calculation of the Cumulative Allowable Growth in All-Payer per Capita Revenue for Maryland Residents

	CY 2014 A	CY 2015 B	CY 2016 C	CY 2017 D	CY 2018 E	Cumulative Growth F = (1+A)*(1+B)*(1+C)*(1+D)*(1+E)
Calculation of Revenue Cap	3.58%	3.58%	3.58%	3.58%	3.58%	19.23%

Table 4 below shows the allowed all-payer growth in gross revenues. Staff has removed adjustments due to reductions in UCC and assessments that do not affect the hospitals' bottom lines. Staff projects that the actual cumulative growth, excluding changes in UCC and assessments, through FY 2018 is 15.47 percent. The actual and proposed revenue growth is well below the maximum levels.

Table 4. Evaluation of the Proposed Update's Projected Growth and Compliance with the All-Payer Gross Revenue Test

	A Actual Jan- June 2014	B Actual FY 2015	C Actual FY 2016	D Staff Est. FY 2017	E Proposed FY 2018	F = (1+A)*(1+B)*(1+C)*(1+D)*(1+E) Cumulative Through FY 2018
Maximum Gross Revenue Growth Allowance	**2.13%**	**4.21%**	**4.06%**	**3.95%**	**3.95%**	**19.68%**
Revenue Growth for Period	0.90%	2.51%	2.47%	2.23%	3.14%	11.76%
Savings from UCC & Assessment Declines that do not Adversely Impact Hospital Bottom Line		1.09%	1.40%	0.69%	0.18%	3.40%
Revenue Growth with UCC & Assessment Savings Removed	0.90%	3.60%	3.87%	2.92%	3.32%	**15.47%**
Revenue Difference from Growth Limit						**4.21%**

"Maximum Gross Revenue Growth Allowance" includes the following population estimates: FY16/CY15 = 0.46%; FY17/CY16 = 0.36%

Note: The figures in the table above are different than the net revenue figures reported at the beginning of this section of the report. The figure above does not reflect actual UCC or include other adjustments between gross and net revenues such as denials. They reflect adjustments to gross revenue budgets.

Medicare Financial Test

The proposed balanced update also keeps Maryland within the constraints of the Model's Medicare savings test. This second test requires the Model to generate $330 million in Medicare fee-for-service (FFS) savings in hospital expenditures over five years. The savings for the five-year period were calculated assuming that Medicare FFS hospital costs per Maryland beneficiary would grow about 0.50 percent per year slower than the Medicare FFS costs per beneficiary nationally after the first performance year (CY 2014).

Performance years one and two (CY 2014 and CY 2015) of the Model generated approximately $251 million in Medicare savings. Performance year three (CY 2016) savings have not yet been

audited, but current staff projections show an estimated savings of $287 million, bringing the three-year cumulative savings to over $538 million. Under these calculations, the cumulative savings are ahead of the required savings of $132 million.

However, there continues to be a shift toward greater utilization of non-hospital services in the state relative to national rates of growth. When calculating savings relative to total cost of care, the three-year cumulative savings estimate is $364 million, still well above the required savings level. Maryland's All-Payer Model Agreement with CMS contains requirements relative to the total cost of care, which includes non-hospital cost increases. The purpose is to ensure that cost increases outside of the hospital setting do not undermine the Medicare hospital savings that result from the Model implementation. If Maryland exceeds the national total cost of care growth rate by more than 1.00 percent in any year or exceeds the national total cost of care growth rate in two consecutive years, Maryland is required to provide an explanation of the increase and potentially provide steps for corrective action.

Staff has estimated that the total cost of care growth is below the national growth for CY 2016. However, Maryland non-hospital cost growth exceeds the national growth rate for CY 2016. This difference appears to be driven by increases in Maryland's non-hospital Part B services, which include clinic and professional fees. Staff determined that the growth is primarily in professional fees and is conducting further assessments of the cause of these increases. A commitment to continue the success of the first three year is critical to building long-term support for Maryland's Model. Therefore, staff recommends maintaining the goal used in the RYs 2015, 2016 and 2017 updates of growing Maryland hospital costs per beneficiary about 0.50 percent slower than the nation for RY 2018. Attainment of this goal will maintain any ongoing savings from prior periods and help achieve savings in the total cost of care, as well as provide evidence of the model's continued success.

Consideration of National Cost Figures

Medicare's Proposed National Rate Update for FFY 2018

CMS published proposed updates to the federal Medicare inpatient rates for FFY 2018 in the Federal Register in mid-April 2017.[2] These updates are summarized in the table below. These updates will not be finalized for several months and are subject to change. In the proposed rule, CMS would increase rates by approximately 2.90 percent in FFY 2018 compared to FFY 2017, after accounting for inflation, a disproportionate share increase, and other adjustments required by law. The proposed rule includes an initial market basket update of 2.90 percent for those hospitals that were meaningful users of electronic health records in FFY 2016 and for those hospital that submitted data on quality measures, less a productivity cut of 0.40 percent and an additional market basket cut of 0.75 percent, as mandated by the ACA. This proposed update

[2] See https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2018-IPPS-Proposed-Rule-Home-Page-Items/FY2018-IPPS-Proposed-Rule-Regulations.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=ascending.

also reflects a proposed 0.4588 percentage point increase for documentation and coding required by the American Taxpayer Relief Act of 2012 and a proposed reduction of approximately 0.60 percentage points to remove the Two-Midnight rule payment increase made in FY 2017 that was deemed to be unlawful. Disproportionate share payment changes resulted in an increase of approximately 1.30 percent from FFY 2017.

Table 5. Medicare's Proposed Rate Updates for FFY 2018

	Inpatient	Outpatient
Base Update		
Market Basket	2.90%	2.90%
Productivity	-0.40%	-0.40%
ACA	-0.75%	-0.75%
Coding	0.46%	
Two Midnight Rule	-0.60%	
	1.61%	1.75%
Other Changes		
DSH	1.30%	0.00%
Outlier Adjustment	0.00%	0.00%
	1.30%	0.00%
	2.9%	1.8%

Applying the inpatient assumptions about market basket, productivity, and mandatory ACA outpatient savings, staff estimates a 1.80 percent Medicare outpatient update effective January 2018. This estimate is pending any adjustments that may be made when the final update to the federal Medicare outpatient rates is published.

Meeting Medicare Savings Requirements and Total Cost of Care Guardrails

For the past three updates, Maryland obtained calendar year Medicare fee-for-service growth estimates from the CMS Office of the Actuary. Staff then compared Medicare growth estimates to the all-payer spending limits. For each of the three past timeframes, all-payer growth outpaced Medicare growth on a per capita basis. For the past three updates, staff adjusted the all-payer growth limit using the difference in Medicare and all-payer per capita growth to estimate the implied limit for Medicare. Staff also incorporated a targeted Medicare savings of 0.50 percent of in hospital payment growth relative to the national growth rate, designed to provide at least $330 million in cumulative savings over a 5-year period.

If the projections from the CMS Office of the Actuary are correct, the projected national Medicare fee-for-service per capita hospital spending will increase by 1.60 percent in CY 2017 and by 2.30 percent for total cost of care (Part A&B). For CY 2018, the projections show 3.10 percent for per capita hospital spending and 2.40 percent for total cost of care per capita. The proposed update in this recommendation is for FY 2018. Therefore, staff has used an average of

CY 2017 and CY 2018 projections from the President's FY 2018 Budget to calculate Medicare growth on line A in Table 6A and 6B below. In 2016, hospitals focused on Medicare spending and avoidable utilization, and this proved to be successful in CY 2016. The staff recommends that the Commission again focus hospitals on this imperative.

For the purposes of evaluating the maximum all-payer spending growth that will allow Maryland to meet the per capita Medicare FFS target, the Medicare target must be translated to an all-payer growth limit (Table 6A and 6B). There are several ways to calculate the difference between Medicare FFS and all-payer growth rates using recent data trends. A consultant to CareFirst developed a "difference statistic' that reflected the historical increase in Medicare per capita spending in Maryland which was lower than all-payer per capita spending growth. CareFirst has updated this statistic each year using data provided by HSCRC staff. For the FY 2018 update CareFirst calculated a conservative difference of 1.36 percent, which used a 3-year average difference reduced by the average absolute variance.

An alternative approach to calculating the difference statistic is to use the compounded annual growth rate difference (CAGR) from RY 2013 to RY 2016, which like the conservative difference statistic controls for volatility. Using CAGR, staff has calculated a difference statistic of 1.50 percent.

Staff calculated two different scenarios using the difference statistic. Under the first scenario (Table 6A), the maximum all-payer per capita growth rate that will allow the state to realize a 0.50 percent FY 2018 Medicare savings is 3.61 percent. Table 6A utilizes the difference statistic developed by CareFirst. The second scenario (Table 6B) shows a maximum all-payer per capita growth rate of 3.75 percent and utilizes the difference statistic based on CAGR. Both scenarios are pictured below. The proposed update for FY 2018 produces a growth that is lower than either of these figures

Table 6A. Scenario 1 Maximum All-Payer Increase that will still produce the Desired FY 2018 Medicare Savings

Maximum Increase that Can Produce Medicare Savings		
Medicare		
Medicare Growth (CY 2017 1.6%+ CY 2018 3.1%)/2	A	2.35%
Savings Goal for FY 2018	B	-0.50%
Maximum growth rate that will achieve savings (A+B)	C	1.85%
Conversion to All-Payer		
Actual statistic between Medicare and All-Payer	D	1.36%
Conversion to All-Payer growth per resident (1+C)*(1+D)-1	E	**3.24%**
Conversion to total All-Payer revenue growth (1+E)*(1+0.36%)-1	F	**3.61%**

Table 6B. Scenario 2 Maximum All-Payer Increase that will still produce the Desired FY 2018 Medicare Savings

Maximum Increase that Can Produce Medicare Savings		
Medicare		
Medicare Growth (CY 2017 1.6%+ CY 2018 3.1%)/2	A	2.35%
Savings Goal for FY 2018	B	-0.50%
Maximum Growth Rate that will Achieve Savings (A+B)	C	1.85%
Conversion to All-Payer		
Actual Statistic between Medicare and All-Payer (CAGR)	D	1.50%
Conversion to All-Payer Growth per Resident (1+C)*(1+D)-1	E	**3.38%**
Conversion to Total All-Payer Revenue Growth (1+E)*(1+0.36%)-1	F	**3.75%**

Additionally, staff has analyzed several revenue scenarios and how they impact the Medicare growth for CY 2017. While HSCRC is approving a rate increase for RY 2018, it is focused on the impact on CY 2017 as well as CY 2018. During CY 2016, hospitals undercharged the mid-year GBR limit by approximately $79.7 million, or about 1.00 percent. While the savings generated by this undercharge and the dis-savings that will generated through the recovery of this undercharge in CY 2017 will wash out for the hospital savings requirement, this could affect the total cost of care guardrail. Staff estimates that this could affect the total cost of care growth year-over-year by more than 0.50 percent. Combined with other fluctuations, this could cause Maryland to exceed the 1.00 percent total cost of care growth guardrail. HSCRC staff has requested that CMMI consider this temporary timing difference before noticing a triggering event. CMMI has accepted accounting for the undercharge in the proper calendar year.

Staff is also evaluating the growth in CY 2017 and its likely impact on guardrails. All scenarios presented by staff in the following table adjust for the undercharge.

Table 7. Estimated Position on Medicare Target

Estimated Position on Medicare Waiver Test		
Step 1:		
Actual Revenue CY 2016		16,414,160,613
Allowed Increase		**3.95%**
Maximum Revenue Allowed CY 2017		17,062,519,957
Step 2:		
Approved GBR FY 2017		16,740,527,157
Actual Revenue 7/1/16-12/31/16		8,185,165,864
Projected Revenue 1/1/17-6/30/17	**A**	**8,555,361,293**
Step 3:		
Estimated Approved GBR FY 2018		17,163,766,845
Permanent Update Less .20 set aside		2.90%
Step 4:		
Estimated Revenue 7/1/17-12/31/17 (after 49.73% & seasonality)		8,513,281,951
less Hopkins Payback		(17,594,500)
	B	**8,495,687,451**
Step 5:		
Estimated Revenue CY 2017	**A+B**	**17,051,048,744**
Increase over CY 2016 Revenue		3.88%
Amount Over (Under) Max Revenue		(11,471,213)
Amount Over (Under) Max Revenue with .10 set aside (1/2 year)		(2,975,526)

The steps for the table 7 are described below:

- Step 1: The table begins with actual revenue for CY 2016, with the undercharge of $79.7 million added back for the year. The resulting adjusted revenue amount is increased by growth limit shown in table 6a to provide an estimated of allowed revenue for CY 2017.
- Step 2: The table then shows the approved global revenue for FY 2017 and actual revenue for the last six months of CY 2016 to calculate the projected revenue for the first six months of CY 2017 (i.e. the last six months of FY 2017).
- Step 3: This step shows estimated FY 2018 global budget revenue based on the information that staff has available to date. The permanent update over CY 2016 shows a 2.90 percent increase less the 0.20 percent set aside.
- Step 4: For this step, to determine the calendar year revenues, staff estimates the revenue for the first half of FY 2018 by applying the recommended mid-year split percentage of

49.73 percent to the estimated approved revenue for FY 2018 and hospital specific seasonality adjustments. A reduction in revenues resulting from the temporary rate adjustment for Johns Hopkins Hospital is subtracted from revenues.

- Step 5: This step shows the resulting estimated revenue for CY 2017 and then calculates the increase over CY 2016 Revenue. The final portion of step 5 shows the amount of revenue under the maximum revenue (shown in step 1) with and without the use of the 0.20 percent set-aside.

With the hospital growth rate for Medicare estimated at 1.60 percent per capita for CY 2017 and a difference statistic of 1.36 percent to 1.50 percent, the revenue growth for the calendar year estimated at 3.88 percent will exceed the estimated Medicare growth for the calendar year. Hospitals will need to continue efforts to decrease avoidable utilization and reach a higher difference statistic as they did in CY 2016. Staff also continues to be concerned about the total cost of care growth. While staff does not propose to further limit the increases based on these calendar year tests, staff does recommend careful monitoring and ongoing updates of revenue estimates. Staff also notes the Commission's ability to address unfavorable performance during the rate year.

Stakeholder Input

HSCRC staff worked with the Payment Models Workgroup to review and provide input on the proposed FY 2018 updates. Staff has received and reviewed comments from CareFirst, the Maryland Hospital Association, Medicaid and the Department of Budget Management, and MedChi.

CareFirst expressed concern for the initial draft update and believes that, if the entire revenue growth were to be implemented it would put the State at risk for meeting each of financial tests that are under the All-Payer demonstration. Staff has laid out its careful analysis of the update above, and recommends close monitoring of the situation, in light of higher expected growth in CY 2017.

The Maryland Hospital Association (MHA) and its member hospitals support the staff recommendations for the update to global revenue and non-global revenues for FY 2018. MHA stated that Maryland's hospitals are committed to reducing avoidable hospital utilization and monitoring Medicare total cost of care in order to achieve the goals of the demonstration.

Medicaid and the Department of Budget Management (DBM) expressed concern for the staff's recommendation based on the impact the proposed revenue growth would have on rates as well as the effect the advanced payment to Johns Hopkins Hospital will have on the Medicaid Budget. In addition, Medicaid and DBM believe that the set-aside for unknown adjustments is unjustified and not needed at this time. Staff will exclude the set-aside from the MCO update calculation it makes for the first half of the year, and will work with Medicaid to determine if it is warranted for the mid-year update. Staff recommends that Medicaid and HSCRC work together with hospitals to identify opportunities for reduced utilization that could improve the budgetary outcomes for Medicaid on an ongoing basis.

MedChi, The Maryland State Medical Society, submitted a letter in support of the staff recommendation. MedChi further supports an increase beyond the recommendation for hospitals that participate in care redesign and gainsharing with physicians as an incentive, to help accelerate uptake on the two new care redesign programs and initiatives. The Secretary of Health is organizing an input group to accelerate discussions regarding initiatives that could be implemented January 1 or before. Under the new Care Redesign Amendment, the State may update and expand programs, many with a 30-day approval cycle.

See Appendix II for all written comments on the staff recommendation for the FY 2018 update factors.

RECOMMENDATIONS

Based on the currently available data and the staff's analyses to date, the HSCRC staff is providing the following final recommendations for the FY 2018 update factors.

For Global Revenues:

a) Provide an overall increase of 3.14 percent for revenue (net of UCC offset) and 2.77 percent per capita for hospitals under Global Budgets, as shown in Table 2. In addition, staff is proposing to split the approved revenue into two targets, a mid-year target and a year-end target. Staff will apply 49.73 percent of the Total Approved Revenue to determine the mid-year target and the remainder of revenue will be applied to the year-end target. Staff is aware that there are a few hospitals that do not follow this pattern of seasonality and will adjust the split accordingly.

b) Allocate 0.28 percent of the inflation allowance based on each hospital's proportion of drug cost to total cost. In addition to an adjustment for drug prices, staff is also proposing a 0.20 percent adjustment for drug volume/utilization, 0.10 percent prospectively allocated to hospitals using the FY 2016 outpatient oncology drug utilization and standard costs filed by hospitals, and the other 0.10 percent based on actual growth for FY 2017 over FY 2016. These adjustments will help fund the rising cost of new outpatient, physician-administered drugs.

c) The Commission should continue to closely monitor performance targets for Medicare, including Medicare's growth in Total Cost of Care and Hospital Cost of Care per beneficiary during the performance year. As always, the Commission has the authority to adjust rates as it deems necessary.

d) Hospitals should renew the GBR amendment that was put into place for FY 2017 that requires a focus on reducing Potentially Avoidable Utilization (PAU) and a continued focus on total cost of care growth, ensuring that hospital savings are not swamped by non-hospital cost growth. Continuing a focus on PAU will be important to meeting

performance needs in the current year. Hospitals should continue to focus on care improvements, working with physician partners in Care Redesign Programs and with ACOs.

e) Continue to consider on an ongoing basis whether to differentiate hospital updates based on progress relative to high needs patients and other aligned efforts with physicians and other providers.

Non-Global Revenues including psychiatric hospitals and Mt. Washington Pediatric Hospital:

a) Provide an overall update of 2.28 percent by using a productivity adjustment of 0.40 percent from the inflation factor of 2.68 percent.

b) Continue to focus on implementation of quality measures and value based programs for psychiatric facilities.

APPENDIX I. DIFFERENTIAL STATISTIC METHODOLOGY – CAREFIRST

Meeting the Dual Waiver Tests of the Demonstration: Calculating GBR Target Budget Increases using the "Differential Statistic"

Report to the Payment Models Work Group
Jack S. Cook
Robert Murray
May 3, 2017

The All-Payer Model Demonstration
Description and Characteristics of the Dual Waiver Tests
The All Payer Test

- The All-Payer Test:
  - Is defined in terms of the **All-Payer Statistic**:
    - Maryland hospital charges for services to Maryland residents calculated annually on a per capita basis
  - Requires that the All-Payer Statistic may not increase by more than 3.58% annually over the term of the Demonstration
  - Can be formulated in each year in terms of parameters that are largely known in advance (prior year increases in the All-Payer Statistic, population growth and the 3.58% annual limitation)

2

The All-Payer Statistic
Annual Increases: 2013-2016

Table 1

Column:	(1)	(2)	(3)	(4)
	Total Hospital Charges to ($1,000,000)	Maryland Population (1,000)	All-Payer Statistic (1)/(2)	Percent Change
Calendar Year:				
2013	$15,623.8	5,931.1	$2,392.99	--
2014	$15,920.5	5,967.3	$2,429.78	1.54%
2015	$16, 377.9	5,995.0	$2,493.77	2.59%
2016	$16,477.1	6,016.4	$2,502.75	0.40%

Data came from the HSCRC Staff

3

The All-Payer Model Demonstration
Description and Characteristics of the Dual Waiver Tests
The Medicare Test

- The Medicare Test:
  - Is defined in terms of the **Medicare Statistic**:
    - All hospital payments for services to Medicare FFS beneficiaries residing in Maryland calculated annually on a per beneficiary basis
  - Requires that the Medicare Statistic may not increase by more than the US average increase in Medicare hospital payment per FFS beneficiary less the annual savings requirement
  - Is formulated in terms of several parameters not known in advance (the US average increase; the level of payments for services to Medicare FFS beneficiaries made to out-of-state hospitals, etc.)

4

The Medicare Statistic
Annual Increases: 2013-2016 (data from CMMI)

Table 2

Column:	(1)	(2)	(3)	(4)
	MD Hospital Charges to FFS Beneficiaries ($1,000,000)	Resident FFS Beneficiaries (1,000)	Medicare Statistic Charges/FFS Beneficiary	Percent Change
Calendar Year:				
2013	$4,664.3	767.3	$6,079.00	-
2014	$4,756.0	792.0	$6,005.24	-1.21%
2015	$4,977.2	816.2	$6,098.04	1.55%
2016	$4,964.6	829.0	$5,988.83	-1.79%

Data are from the CMMI

Note: Estimate does not account for out of area services or changes in the Medicare payment to charge ratio in Maryland

5

The All-Payer Model Demonstration
Meeting the Dual Waiver Tests
The Differential Statistic

- The Differential Statistic:
  - Is defined for 2012 through 2015 as the difference between
    - The annual increase in the All-Payer Statistic, and
    - The annual increase in the Medicare Statistic
  - Allows the HSCRC to unify the Dual Waiver Test requirements into a single limitation
    - In this application of the Differential Statistic methodology the single limitation relates to the Medicare Test as illustrated on Schedule 2 below

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The All-Payer Model Demonstration
Meeting the Dual Waiver Tests

- The Conservative Differential Statistic (DS):
  - As noted, the DS is merely an average of the differences in the rates of growth of the All-Payer Statistic and the Medicare Statistic.
  - Since it is an average historical difference, using the straight average difference to project a future year's results means there is a 50% chance that our estimated DS will be lower than the actual difference and a 50% chance that our estimated DS will be higher than the actual difference.
  - To provide a higher level of conservatism to this analysis, in our original 2013 proposed DS methodology we proposed the use of a Conservative Differential Statistic.

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The All-Payer Model Demonstration
Meeting the Dual Waiver Tests

- The Conservative Differential Statistic (DS) continued:
  - The calculation of the Conservative DS involves an extra step, where we calculate the variance between the DS in a particular year and the average of the DS over all years in our array.
  - The variance that we calculated for each year is the "Absolute Value" of the variance for the particular year.
  - We then average these Absolute Value Variances and subtract this average from the DS to obtain a Conservative DS.
  - This extra step enhances the probability that our projected DS will result in a growth in Medicare hospital expenditures per beneficiary (less the 0.5% savings provision) in Maryland that is below the increase in payments per FFS beneficiaries nationally from 50% to about 80%
  - Schedule 1, on the next slide, summarizes the Staff's calculation of the Differential Statistic and Conservative Differential Statistic using data from 2013-2016.

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Step 1: Calculation of the Conservative Differential Statistic (DS) for FY 2018

HSCRC Data MD Hospital All Payer Claims per Resident

Annual Rate of Change All Payer

CMMI MD Medicare Hospital Claims per Beneficiary

Annual Rate of Change Medicare

Schedule 1

Line	Calendar Year	A All Payer Claims/Resident (1)	B % Change	C Medicare (2) Claim/Benef.	D % Change	E=B-D Differential Statistic	F Annual Absolute Value
1	2013	$2,392.99		$6,079.00			Variance
2	2014	$2,429.78	1.54%	$6,005.24	-1.21%	2.75%	0.75%
3	2015	$2,492.77	2.59%	$6,098.04	1.55%	1.05%	0.95%
4	2016	$2,502.75	0.40%	$5,988.83	-1.79%	2.19%	0.19%
5		Average	1.51%	$6,030.70	-0.49%	1.996%	0.633%
6		Conservative Differential Statistic (L5, Col. E - L5, Col. F)				1.364%	

This is precisely the same Methodology as was used last year to calculate the DS and Conservative DS.

Annual Differential Statistic Calculation Col. B-D

Average DS

Conservative DS = Average DS less Absolute Value Variance 1.996-0.633=1.364

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Step 2: Determine Limitations on the Increase in Allowable Revenue under the All Payer and Medicare Waiver Test Limits

Schedule 2

The All Payer Limit:

1. The Annual Allowed Increase in Charges/Resident:	3.58%
2. Projected CY 2017 Increase in Maryland Population:	0.36%
3. All Payer Test Limitation (L1+L2)	3.94%

The Medicare Hospital Waiver Limit:

4. Projected Increase in U.S. Hospital Expend. per FFS Medicare Beneficiary:	2.70%
5. Annual Maryland Savings Target (reflects desired annual savings or cushion)	(0.50%)
6. Allowed Increase in Hospital Expend. per Maryland FFS Beneficiary (L4+L5)	2.20%
7. Conservative Differential Statistic (From Schedule 1, L6, Col. E)	1.36%
8. Allowed Increase in Charges per MD Resident (L6+L7)	3.56%
9. Projected 2017 Increase in Maryland Population	0.36%
10. Medicare Waiver Test Limitation (L8+L9)	3.92%

Key Observations:

- It appears that the All Payer and the Medicare Hospital Waiver Limits are nearly identical
- We will focus on meeting the Medicare Hospital Limit because it is slightly lower
- Per this application of the Differential Statistic, Maryland Aggregate All Payer GBR revenue can grow by 3.92% above the prior calendar year's approved revenue and still meet both the Medicare and All Payer Limits

Step 3: Determine the Aggregate Aggregate Charge Data from Selected Six Month Periods

- We received aggregate charge data from the Staff for the three six month periods:
  - First Half FY 2016 (i.e., 7/1/15 - 12/31/15)
  - Last Half FY 2016 (i.e., 1/1/16 – 6/30/16)
  - First Half FY 2017 (i.e. 7/1/16 – 12/31/16)
- We need these six month amounts to determine charge levels in the FH CY17 (i.e., January – June 2017 or LH FY17)
- Once we have an estimate of LH FY17 (i.e., FH CY 17) charges, we can compare that to what is allowed for the Full CY 17 and determine what the hospitals can charge for the second half of CY 17 to meet the Medicare Waiver test.

Schedule 3

Line	Period	Dates:	Amounts ($000,000)	
1	FH FY 2016	7/1/15 - 12/31/15	$8,189.5	FY 16
2	LH FY 2016	1/1/16 - 6/30/16	$8,229.0	
3	FH FY 2017	7/1/16 - 12/31/16	$8,105.4	CY 16

- We also convert these numbers to average six month aggregate charges based on CY 16 and FY 16 charges. We use these numbers later.

Schedule 3A

	Total Charge	Average Six Month Charges
CY 2016 and Avg 6 month period (L2+L3)	$16,334.4	$8,167.2
FY 2016 and Avg 6 month period (L1+L2)	$16,418.5	$8,209.3

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Step 4: Calculate First Half (FH) Calendar Year 2017 (LH FY17) Aggregate Charges based on data provided by Staff

- Staff indicated that charges in the last six months of FY17 are projected to go up by **4.34%** over the same period in FY16 – shown by staff to be $8,229,000,000 (from Sched. 3, line 2)

Schedule 4

		in ($000,000)	
1	Aggregate Charges in LH FY16	$8,229.0	← FH CY16
2	Projected increase by staff	1.0434	← Per Staff
3	Projected Aggregate Charges LH FY 17	$8,586.1	

- So, we expect that First Half CY 17 (LH FY 17) charges (including both Permanent and Temporary components) will be this amount: $8,586.1 mill. (i.e., $8,229 m. LH FY 16 Revenue x 1.0434)

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Step 5: Calculate the Temporary & Permanent Revenue Components of the $8,586.1 mill. of FH CY17 Revenue

- To determine what portion of the $8,586.1 m is Permanent, Staff indicated that they expected Aggregate FY 2017 Base Revenue to be 1.83% above FY 2016 Revenue
- From Schedule 3A, we know that FY 2016 Revenue was $16,418.5 mill.
- Six month average Revenue for FY 2016 is $16,418.5/2 = $8,209.3 mill.
- We therefore assume that of the $8,586.1 mill. charged in FY CY 2017, $8,359.5 mill. is Permanent Revenue ($8,209.3 x 1.0183 = $8,359.5)
- This means that the Temporary component of the $8,586.1 mill. in charges in FY CY17 is $226.6 mill. ($8,586.1 - $8,359.5 – $226.6)

Schedule 5

	($000,000)	
Average Charge CY 16	$8,209.3	← 6 month Avg. Charge Level FY2016 from Sched. 3A above
Permanent increase per Staff	1.0183	← Per Staff
Permanent component of Charges LH FY17	$8,359.5	← Permanent Revenue
Estimated Aggregate Charges LH FY 17	$8,586.1	
Temporary is the difference between total and Perm	**$226.6**	← Temporary Revenue

- We now have the basis for estimating Aggregate Revenue for CY 2017 – both the actual amount charged FH CY 17 ($8,586.1 m) and the Permanent piece flowing into LH CY 17 ($8,359.1 m)

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Step 6: Compare the Total Revenue Allowed under the Waiver Test Limits to Amounts Charged in FH CY17 Plus Permanent Revenue flowing into the LH of CY 17

- Having determined the amounts charged in FH CY17 (and the amounts permanently carrying over into Last Half CY17) we can now determine how much more Maryland Hospital GBR revenues can grow in the Last Half of CY17 (via the FY18 Update Factor) to allow Maryland to meet the Medicare Waiver Test Limitation.
- We understand Staff may be seeking CMS permission to accrue amounts ($79.7 m) approved revenue not charged in FH FY 2017 (i.e., undercharged in LH CY 16) back to the CY 2016 for Waiver Test Compliance purposes
- Therefore, we will calculate Total Allowed GBR Revenue in CY 2017 both assuming:

  1) No reallocation of the CY 16 undercharged revenue (of $79.7 mill.) back to CY;

  2)Under the assumption CMS **allows the State to accrue** the amounts undercharged in Last Half of CY 2016, back to CY 2016 for purposes of the Waiver Test Compliance calculations (in which case they would not count against the Wavier Test limits for CY17)

- Schedule 6 (on the next slide) shows the impact of this reallocation on CY17

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Step 6: Accounting for Possible Accrual of CY 2016 (i.e., LH FY 17) "Undercharges" back to CY 2016 for the purposes of the Waiver Compliance

- Schedule 6 shows the impact on LH CY 16 and FH CY 17 Revenues, if CMS allows Maryland to accrue undercharges in LH CY 16 (FH FY 17) back to Calendar Year 2016 for Waiver Test Compliance purposes

Schedule 6

	(in $000,000)	A Actual	B FH FY 2017 Undercharge	C Reallocated
1	FH FY16 July - Dec 2015	$8,189.5		$8,189.5
2	LH FY16 Jan - June 2016	$8,229.0		$8,229.0
3	FH FY17 July - Dec 2016	$8,105.4	$79.70	$8,185.1
4	Avg CY 16	$8,167.2		$8,207.1
5	Est. 1/1/17-6/30/17 Charges	$8,586.1	-$79.70	$8,506.4

Undercharged amount here ($79.7 m)in LH CY16 (FH FY17)

Would be reallocated here back to CY 16

With a corresponding reduction to amounts charged in CY 17

- Schedules 7 and 7A calculate the Allowed Aggregate GBR Revenue Increase for FY 2018 under both scenarios

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Step 7: Calculate the Allowed increase in Aggregate GBR Revenues necessary to meet the Medicare Waiver Test Limitation for CY 2017 (no Reallocation)

Scenario 1: Assuming no Reallocation of $79.7 m. Undercharges back to CY16

- Schedule 7 calculates the Allowed Total GBR Revenue Increase effective 7/1/17 (RY 18)

This is done based on an accounting of actual charged amounts in FH CY 17 ($8,586.1 m – see line 6 in Schedule 7) and Permanent amounts flowing into FY 2018 (which will be charged in the LH CY 17 ($8,359.5 m. see line 8 Schedule 7)

It is also based on the 3.92% Limitation in All-Payer Aggregate Revenue growth in CY 2017 (of $16,974.7 m.) from the application of the Differential Statistic Methodology

Schedule 7

		(in $000,000)	
1	FH CY16 actual	$8,229.0	
2	LH CY 16 actual	$8,105.4	
3	Annual CY 16	$16,334.4	← Per HSCRC Staff
4	Allowed Increase	1.0392	Pct. Charge Growth Limit from Schedule 2
5	Allowed CY17 Charges L3 x L4	$16,974.7	Allowed CY17 Rev. to meet Medicare Limit
6	FH CY17 Charges From Sched. 6 line 5 col A.	$8,586.1	Amounts Charged in FH CY17 (Schedule 4)
7	Allowed LH CY 17 Charges L5-L6	$8,388.6	Additional Allowed Chg. Growth in LH CY17
8	Permanent portion From Schedule 5	$8,359.5	Permanent amounts flowing into LH CY17
9	Allowed Increase 7/1/17 (L7/L8)-1	0.348%	← This reflects the pct. amount aggregate GBR Revenues can increase in LH CY17 above the permanent approved revenue as of 7/1/17 and still meet Waiver Limit

It also assumes no reallocation Of the $79.7 m. in undercharges

($8,388.6 m/$8,359.5 m.) -1 = 0.348%

Step 7A: Calculate the Allowed increase in Aggregate GBR Revenues necessary to meet the Medicare Waiver Test Limitation for CY 2017 (with Reallocation)

Scenario 2: Assumes Reallocation of $79.7 m. in Undercharges back to CY16

- Schedule 7 calculates the Allowed Total GBR Revenue Increase effective 7/1/17 (RY 18)

  This is done based on an accounting of actual charged amounts in FH CY 17 ($8,506.1.1 m – see line 6 in Schedule 7A) and Permanent amounts flowing into FY 2018 (which will be charged in the LH CY 17 ($8,359.5 m. see line 8 Schedule 7A)

  It is also based on the 3.92% Limitation in All-Payer Aggregate Revenue growth in CY 2017 (of $17,057.5 m.) from the application of the Differential Statistic Methodology

Schedule 7A

			(in $000,000)
1	FH CY16 actual		$8,229.0
2	LH CY 16 actual (reallocated)		$8,185.1
3	Annual CY 16		$16,414.1
4	Allowed Increase		1.0392
5	Allowed CY17 Charges	L3 x L4	$17,057.5
6	FH CY17 Charges	From Sched. 6 line 5 col C.	$8,506.4
7	Allowed LH CY 17 Charges	L5-L6	$8,551.1
8	Permanent portion	From Schedule 5	$8,359.5
9	Allowed Increase 7/1/17 (L7/L8)-1		2.292%

($8,551.1 m/$8,359.5 m.) -1 = 2.292%

It also assumes the $79.7 m. in Undercharges are reallocated

← Per HSCRC Staff

Pct. Charge Growth Limit from Schedule 2

Allowed CY17 Rev. to meet Medicare Limit

Amounts Charged in FH CY17 (Schedule 4)

Additional Allowed Chg. Growth in LH CY17

Permanent amounts flowing into LH CY17

← This reflects the pct. amount aggregate GBR Revenues can increase in LH CY17 above the permanent approved revenue as of 7/1/17 and still meet Waiver Limit

Summary and General Observations

- Application of the Differential Statistic Methodology in the context of the Fy2018 Update would result in the following Updates under different assumptions regarding the allocation of the $79.7 million in undercharges to CY 2016

Assumes a CMS Actuary Forecast for US Hospital Expenditure per FFS Beneficiary of 2.70% for CY 2017

Result assuming no reallocation of the $79.7 m in undercharges in the FH FY 2017 to CY 2016 — 0.35%

Result assuming a reallocation of the $79.7 m in undercharges in the FH FY 2017 to CY 2016 — 2.29%

- These results would also include a reversal of the Temporary component of $226.6 m. effective 7/1/17

APPENDIX II. COMMENT LETTERS ATTACHED

CareFirst – May 9, 2017

Maryland Hospital Association – June 2, 2017

Medicaid Program and Department of Budget and Management – June 2, 2017

MedChi – June 5, 2017

CareFirst – June 8, 2017

Chet Burrell
President and Chief Executive Officer

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May 9, 2017

Nelson J. Sabatini, Chairman
Donna Kinzer, Executive Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Mr. Sabatini and Ms. Kinzer:

The purpose of this letter is to provide CareFirst's comments on the HSCRC staff's "Draft Recommendations on the Update Factors for FY 2018." In short, we urge the Commission to reject the Staff's recommendation of 3.39% and to develop a new recommendation for the Commission's consideration. The reasons for this are outlined below.

CareFirst believes that the recommended Update Factor—if implemented—would jeopardize the State's prospects of meeting all three of the financial tests that are required under the Maryland Model Demonstration. Specifically, based on a forecasting methodology (the "Differential Statistic Methodology" or "DSM") that was accepted by the HSCRC staff, we estimate that if the 3.39% Update Factor is implemented, the following would occur:

1) Maryland's growth in all payer costs would (according to the DSM) rise to 5.4%, exceeding the 3.94% target. This percent is based on the fact that hospital revenues will dramatically increase in CY 2017—as detailed under the HSCRC's own projections. The 5.4% increase in CY2017 over CY2016 is the result of a lower CY2016 charge base (denominator) due to the $70M undercharge and the higher CY2017 period (numerator) driven, in part, by hospitals' upcharge to recover the previous year's undercharge.

2) Medicare savings would decrease by $93 million relative to savings that would occur had Maryland met the goal of growing at U.S. Medicare hospital per beneficiary growth less 0.5% in CY 2017. CareFirst projects that under the recommended Update Factor, Maryland Medicare Hospital Expenditures per Medicare Beneficiary would increase 3.75 percent, significantly greater than what CMS currently projects for the rest of the US. We estimate the US target to be 2.2 percent (after taking out 0.5 percent as is required). We ask how this estimate can be reconciled with the 3.75 percent presented for the State's Update Factor and given its focus on meeting the targets under the Demonstration.

3) Maryland would likely exceed the Medicare Total Cost of Care (TCOC) Test if non-hospital Medicare FFS expenditures continue to grow at a rate that exceeds the national U.S. non-hospital Medicare FFS increases per beneficiary by approximately 1.5%, as has been the average for the past two years. Under this assumption, we estimate that Medicare TCOC in Maryland would increase by 3.41—a level of 1.31 percentage points greater than the State's target.

Thus, it appears as though the staff recommendation has not taken into account the impact of the actual increases in hospital costs that will occur in CY 2017 on these three Demonstration targets, after a period of hospital undercharges in the second half of CY 2016.

At such a critical time when the State is negotiating the future of the Demonstration with the federal government, we believe it is imperative that the HSCRC consider an Update Factor that is more conservative. Considering that hospital revenue is projected to be 4.3% higher in the first half of 2017 than in 2016—due to deferrals and undercharges in the last half of 2016—a very low Update Factor is implied.

We would also point out that Maryland hospitals have consistently generated total operating margins that have hovered around 3.0% and operating margins from rate-regulated activities that have exceeded 8.0% during the term of the Demonstration. We also note that hospitals received $239 million in FY 2015 and FY 2016 for Care Management Infrastructure funding, with $200 million added to rates for every subsequent FY. To date, neither we nor anyone else to our knowledge has been able to determine how these funds were spent to improve care coordination or outcomes. It concerns us that recent HSCRC reporting seems to indicate that these funds were largely spent to subsidize Part B physician activities.

For these reasons we strongly urge the Commission to direct staff to develop a proposed Update Factor that better protects the State against failing to comply with the thresholds provided under the Demonstration and to make this proposal in time for the Commission to consider at its June meeting.

Sincerely,

Chet Burrell
President & CEO

Maryland
Hospital Association

June 2, 2017

Nelson J. Sabatini
Chairman, Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Chairman Sabatini:

On behalf of the Maryland Hospital Association's 64 member hospitals and health systems, I am writing to support the staff recommendation for the update to global budgets and non-global budget revenues for fiscal year 2018. As the draft recommendation notes, significant progress has been made in the past three years toward achieving the goals of the All-Payer Model demonstration, with Medicare hospital savings far exceeding the requirements through calendar year 2016, and the quality improvement goals of reductions in readmissions and hospital-acquired conditions well on track. These accomplishments were accelerated by the commission and its staff, including the infrastructure investments, recognition of high-cost drug growth, and other funding provided in the model's first three years. Together, we must continue to ensure future progress toward the Triple Aim goals of the demonstration, and the funding recommended in the 2018 update will help make that possible.

At the same time, Maryland's hospitals also recognize the need to continue to reduce avoidable hospital utilization. ***Maryland's hospitals – individually and collectively – are committed to transforming the delivery of care and to the challenge of further reducing avoidable hospital utilization.*** Hospitals are keenly aware that the funding provided for next year demands that the Medicare total cost of care be monitored closely, to ensure that growth in non-hospital spending is more than offset by reductions in avoidable hospital utilization. We hope that the addition of the two Care Redesign Programs for next year will also help accomplish the demonstration's goals.

We look forward to discussing this update at the commission's meeting on June 14, and to continue to work together on behalf of the patients and communities we serve.

Sincerely,

Michael B. Robbins

Michael B. Robbins, Senior Vice President

cc: Herbert S. Wong, Ph.D., Vice Chairman
Joseph Antos, Ph.D.
Victoria W. Bayless
George H. Bone, M.D.
John M. Colmers
Jack C. Keane
Donna Kinzer, Executive Director
Caitlin Grim, Health Services Rate Analyst
Deon Joyce, Health Services Rate Analyst

STATE OF MARYLAND
DHMH
Maryland Department of Health and Mental Hygiene
Larry Hogan, Governor - Boyd K. Rutherford, Lt. Governor - Dennis R. Schrader, Secretary

June 2, 2017

Nelson J. Sabatini
Chair
The Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Chairman Sabatini:

The Medicaid program and the Department of Budget and Management (DBM) have jointly reviewed the draft recommendation of the Health Services Cost Review Commission's (HSCRC) Staff for the fiscal year (FY) 2018 Update Factor. We are writing to express our concern regarding the Staff's draft recommendation of 3.34 percent revenue growth (net of offsets; 2.97 percent revenue growth per capita). For the reasons described below, we feel that the proposed Update Factor is not financially-sustainable for the Medicaid program and for the state budget collectively.

Impact on the Medicaid Budget

First, and though not unusual, the proposed increase in rates was not entirely planned for in the FY 2018 Medicaid budget. When developing the FY 2018 budget, the Department of Health and Mental Hygiene and DBM did include an assumption for a rate increase of 1.87 percent; however, the Staff recommendation of 3.34 percent far exceeds this amount. We also assumed a utilization trend for inpatient services that has not materialized. This places even greater pressure on the Medicaid budget, which is already projecting a deficit in FY 2018. We would further note that the State is projecting a General Fund deficit in the range of $700 million for FY 2019, and since Medicaid is the State's second largest expenditure, cost controls are needed.

Effect of Temporary Rate Adjustments

The HSCRC approved a temporary advanced payment in rates of $75 million to Johns Hopkins during the first six months of calendar year (CY) 2018. The $75 million will be repaid via rate reductions over the course of three years. Unscheduled advanced hospital payments of this magnitude have a significant

impact on the Medicaid budget and are contrary to the goals of requiring the hospitals to operate under the global budget revenue (GBR) system.

Placeholder for Unknown Adjustments

Lastly, the FY 2018 Update Factor includes a placeholder for unknown adjustments. The amount allocated—0.4 percent—is larger than other line items of significance, including drug cost inflation (0.28 percent) and the demographic adjustment (0.36 percent). Unless additional detail is provided to justify its inclusion, the Medicaid program contends that this item is unnecessary.

Both departments understand the value of the global budget revenue (GBR) approach to hospital financing, which constitutes a powerful tool for transforming health care from volume to value-based reimbursement and investing in improvements to support that transformation. We look forward to working with the HSCRC and other stakeholders as the Update Factor is finalized for FY 2018. If you have any questions, please contact Tricia Roddy, Director for the Medicaid Office of Planning at tricia.roddy@maryland.gov or Jennifer McIlvaine, Supervising Budget Analyst at DBM at jennifer.mcilvaine@maryland.gov.

Sincerely,

Shannon M. McMahon
Deputy Secretary, Health Care Financing
Department of Health and Mental Hygiene

Marc Nicole
Deputy Secretary
Department of Budget and Management

MedChi
The Maryland State Medical Society

Your Advocate.
Your Resource.
Your Profession.

June 5, 2017

The Honorable Nelson Sabatini, Chair
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215
Sent via Email to Donna.Kinzer@maryland.gov

Re: FY2018 Hospital Update Factor

Dear Chairman Sabatini:

MedChi, The Maryland State Medical Society, on behalf of Maryland physicians, is writing to support the HSCRC Staff recommendation update of 3.12% in total revenues for FY2018. An update of 3.12% would cover any inflationary expenses of hospitals and ensure that employed physicians continue to be appropriately compensated for their services.

Furthermore, MedChi suggests that an increase beyond the recommended 3.12% be made available to hospitals that participate in care redesign / gainsharing programs with physicians. Starting this year, physicians must report data to the Centers for Medicare and Medicaid Services (CMS), which will reward or penalize physicians financially, based on the submitted data. Physicians can receive a separate reward for participating in an advanced alternative payment model (APM.) However, Maryland physicians are at a disadvantage because some payment models cannot be implemented in Maryland due to Maryland's unique All-Payer Model. CMS has corrected for this problem by allowing the creation of two new care redesign programs that are APM programs.

Unfortunately, the uptake on the two new programs to date has been slow. We would recommend allowing additional funds to participating hospitals as an incentive on top of the update. While MedChi supports the two care redesign programs (Internal Cost Savings and Pay-for-Outcomes) that are already developed, MedChi believes that an additional increase for participating hospitals would help further (1) align hospitals with non-employed physicians and community providers; and (2) assist hospitals in meeting the objectives and global budget set in the All-Payer Model.

Please let me know if I can provide any more insight on this matter.

Thank you.

Sincerely,

Gene M Ransom III

Gene M. Ransom, III
Chief Executive Officer

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Chet Burrell
President and Chief Executive Officer

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June 8, 2017

Nelson J. Sabatini, Chairman
Donna Kinzer, Executive Director
Health Services Cost Review Commission 4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Mr. Sabatini and Ms. Kinzer:

I write to express CareFirst's grave concerns with the staff's recommended Update Factor of 3.34 for FY 2018. We oppose the increase recommended as too high, threatening the status of the All Payer Waiver and placing unnecessary burdens on our subscribers. CareFirst first expressed its concern with this recommendation at the May meeting and urged the Commission to revise the recommendation. Now, new information from the CMS Office of the Actuary since the May meeting leads us to express an even greater sense of concern.

As reported on page 12 of the staff Report, the Office of the Actuary reduced its projected Medicare hospital expenditures per FFS beneficiary nationally in CY 2017 from 2.7% to 1.6%. Because of this much lower national forecast, we believe that the State is far more likely to exceed three of the key Demonstration tests.

These results will become apparent at the same time that the federal government will decide whether to continue the Demonstration to Phase 2. This is a very unfortunate juxtaposition of events.

Not only will approval of this recommendation risk the future of Maryland's Demonstration, but it will unnecessarily increase health care costs for those paying these costs for Medicare, Medicaid, and the private insurance market. This is particularly concerning at a time of much federal uncertainly about the future of Medicaid and the ACA Marketplace Exchanges.

Therefore, we believe that the Update Factor should be reduced to an amount that will more adequately ensure that the State is able to meet the Demonstration requirements, (particularly the TCOC test) as well as more adequately respect the concerns of payers in the State.

Sincerely,

Chet Burrell
President & CEO

Cc: Joseph Antos
Victoria Bayless
George Bone
John Colmers
Jack Keane
Herbert Wong